

8455

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 4913 Jay St., N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Gail (None) ALLEN		4. DATE OF DEATH Month Day Year August 1 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-56
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wendell Leroy ALLEN		14. MOTHER'S MAIDEN NAME Audrey E. DAWKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Wendell Leroy ALLEN (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURETY 32 WKS GASTATION (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 54 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Aug. 1956, to 1 Aug. 1956, that I last saw the deceased alive on 1 Aug. 1956, and that death occurred at 4:32 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Daniel Shuptar M.D. U.S. Naval Hospital, Bethesda, Md. 8-1-56			
ACTUAL SIGNATURE Daniel Shuptar		PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, MC, USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-56	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis Funeral Home 1432 "U" St., N.W.,	
24a. REC'D BY REGISTRAR DATE 8-1-56		24b. REGISTRAR'S SIGNATURE Mary E. Carrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and must be present within 72 hours after death.

BUREAU V. S.

AUG 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08394 216

8456

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>C</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Bedford Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert M. Namara</u>		14. MOTHER'S MAIDEN NAME <u>Annie Purcell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Phelia H. Allen</u>		Address <u>3707-Woodley Rd DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 14, 1956</u> , to <u>August 3, 1956</u> , that I last saw the deceased alive on <u>Aug. 3, 1956</u> , and that death occurred at <u>1:57 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3921 Ingomar St NW</u>		DATE SIGNED <u>8/3/56</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u>		<u>Wash. DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Entombment</u>	<u>Aug 6/56</u>	<u>Abbey Mausoleum</u>	<u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adams Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Aug 8 1956</u>	
ADDRESS <u>4748 - Wisconsin DC</u>		24b. REGISTRAR'S SIGNATURE <u>Kessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text in the main body of the form, including fields for name, date, and cause of death.]

BUREAU V. S.

AUG 8 1956

RECEIVED

[Faint handwritten text at the bottom of the page, possibly a signature or date.]

8457

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5411 Roosevelt St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MABLE</u> Middle <u>PEARL</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 1, 1873</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Albans, Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM M. HICKOK</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>009-01-5974</u>	
17. INFORMANT <u>Daughter, Bertha E. Woodman</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x massive left cerebral infarct</u> DUE TO (b) <u>Thrombosis left middle cerebral artery</u> DUE TO (c) <u>Atherosclerosis, cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 wks</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG. 10, 1956</u> to <u>AUG. 17, 1956</u> that I last saw the deceased alive on <u>AUG. 17, 1956</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor</u> M.D.		ADDRESS (Street, city or town, state) <u>9600 OLD GEORGETOWN RD. 17 Aug. 56.</u>	
PHYSICIAN'S NAME (Type) <u>Joseph D. Connor</u>		DATE SIGNED <u>Bethesda 14 Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>8/19/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Albans Bay</u>		22d. LOCATION (City, town, or county) (State) <u>Franklin County Vermont</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</u>		24a. REC'D BY REGISTRAR <u>8-20-56</u>	
ADDRESS <u>Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Jessie M. Thompson</u>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8458 CERTIFICATE OF DEATH

88396
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNA b. COUNTY MIFFLIN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JR HARRY ORRIS ANDREWS		4. DATE OF DEATH Month Day Year AUG. 24 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/15
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 10 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLER		10b. KIND OF BUSINESS OR INDUSTRY FEED MILL	
11. BIRTHPLACE (State or foreign country) HARLETON DEPT, PENNA.		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME HARRY O. ANDREWS, SR.		14. MOTHER'S MAIDEN NAME ELEANOR REAHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 210-18-6966	
17. INFORMANT MRS. JEAN ANDREWS-WIFE		Address QUEEN ST, MCUEY TOWN, PENNA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mild Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 days 13 yrs		INTERVAL BETWEEN ONSET AND DEATH 10 days 13 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Aug. 1956 to 24 Aug. 1956 , that I last saw the deceased alive on 23 Aug. 1956 , and that death occurred at 10:40 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. S. Murphy		ADDRESS (Street, city or town, state) 615 W. Montgomery, Rockville, Md.	
PHYSICIAN'S NAME (Type) W. S. Murphy		DATE SIGNED 24 Aug 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 8-27-56	
22c. NAME OF CEMETERY OR CREMATORY I.O.F. Cem.		22d. LOCATION (City, town, or county) (State) Mapleton, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 26-56		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

CERTIFICATE OF DEATH

1958

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BUREAU V. 1

AUG 28 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

8459

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>N</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>2617 South Ridge Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Nita</u> Last <u>ARPS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 March 1900</u>	
9. AGE (In years last birthday) yrs. <u>56</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Nita</u>				14. MOTHER'S MAIDEN NAME <u>Mary Barch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT (Husband) <u>Melvin W. ARPS (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, Cerebral</u> DUE TO <u>Hypertensive Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u> <u>Indefinite</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>13 July</u> , 19 <u>56</u> , to <u>10 August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 August</u> , 19 <u>56</u> , and that death occurred at <u>3:55 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. J. Mc Carthy</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>			
DATE SIGNED <u>8-11-56</u>							
PHYSICIAN'S NAME (Type) <u>R. J. Mc CARTHY, CDR, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>8-10-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Passolunghi</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3300

BUREAU V. S.

AUG 14 1956

RECEIVED

8460

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE District of Columbia D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 mo. 27 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 906 Madison Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First kimberly Middle JO Last ASHBURN				4. DATE OF DEATH Month August Day 5 Year 1956			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3 June 1956	
9 AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours Min. 		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Darwin ASHBURN				14. MOTHER'S MAIDEN NAME Mary Jo CLATTERBUCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT (Father) Darwin ASHBURN (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Meningomyelocel congenital DUE TO (c) 8 weeks				INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8 June , 19 56 , to 5 August , 19 56 , that I last saw the deceased alive on 5 August , 19 56 , and that death occurred at 02:30A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-5-56 ACTUAL SIGNATURE John H. Mazur M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) John H. MAZUR, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-56		22c. NAME OF CEMETERY OR CREMATORY Oakland, Maryland		22d. LOCATION (City, town, or county) (State) Oakland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Birch Funeral Home ADDRESS 3034 M Street NW, Washington D.C.				24a. REC'D BY REGISTRAR DATE 8-5-56		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU A. A.

NOV 2 1951

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

8414

CERTIFICATE OF DEATH

08399

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MONTGOMERY
 City or town TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? ..
 Hospital, institution, or street address where death occurred:
CEDAR HAVEN NURSING HOME
 How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County MONTGOMERY
 City or town CHEVY CHASE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4217 FALLSIDE AVE
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Helen L BAIRD

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

MARCH, 7, 1872

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

84

..... hrs. min.

9. Birthplace

NEBRASKA

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

FATHER

12. Name

WILLIAM L. LEBERT

13. Birthplace

FRANCE

MOTHER

14. Maiden name

LAVINA ADAMS

15. Birthplace

IOWA

RECORD:

16. Informant

CEDAR HAVEN NURSING HOME

Address

7300 BALTIMORE AVE, TAKOMA PARK, MD

17.

Burial

Date thereof

8-31-56

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rock Creek Cem.

Location

Washington, DC

18. Funeral director

H. B. B. Co.

Address

2901-14th St. N.W., Wash. DC

19.

8-29-56

19.

Francis W. B. B.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 29

19

56 at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5

19

to

10

to

10

to

10

to

10

to

10

to

10

to

10

Immediate cause of death

Myocardial degeneration
with mural thrombosis
abdominal aortic aneurysm

DURATION

14 weeks
2 mo +
3 mo +

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Tracy Port Baker MD

Address

1635 Howard St. Wash DC

Date signed

8-29-56

RECEIVED

AUG 21 1956

RECEIVED

8461

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 186 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5909 Wilmett Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jana Middle Marie Last Bartelt				4. DATE OF DEATH Month August Day 15 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1944	
9. AGE (In years last birthday) yrs. 12		IF UNDER 1 YEAR Months 12 Days 15 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Bartelt				14. MOTHER'S MAIDEN NAME Anna Pochmanova			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia left lung field DUE TO (c) acute myelogenous leukemia INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 11, 1956 to August 15, 1956 , that I last saw the deceased alive on August 15, 1956 , and that death occurred at 12:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center 8-15-56 DATE SIGNED NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Thomas Waldman, M.D.							
PHYSICIAN'S NAME (Type) Thomas Waldman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORY Port Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR 8-17-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHURCHILL W. A.

AUG 28 1956

PAID

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08401

8462

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN SILVER SPRING		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING			
HOSPITAL OR INST. T. ON OR STREET ADDRESS 12,003 ASHLEY DRIVE				STREET ADDRESS (If rural give location) 12,003 ASHLEY DRIVE			
3. NAME OF DECEASED (First) (Middle) (Last) CHARLES GLENN BARTON				4. DATE OF DEATH (Month) (Day) (Year) AUG. 22 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MARCH 4, 1882	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Structural Engineer		10b. KIND OF BUSINESS OR INDUSTRY (Retired) U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Stanton, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Barton				14. MOTHER'S MAIDEN NAME Louisa S. Calvert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs. Laura W. Barton, 2813 Randolph Rd. Silver Spring, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				Coronary occlusion arterio-sclerosis Interval between onset and death 7 1/2 hours 6 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 16, 19 56, to Aug 22, 19 56, that I last saw the deceased alive on Aug 22, 19 56, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
SIGNATURE Michael D. O'Leary		M.D. 12201 Rocking Dr. White		DATE SIGNED Aug 23, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8/25/56		NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
24. REC'D BY REGISTRAR DATE 8-29-56		REGISTRAR'S SIGNATURE Frances Potter		25. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		ADDRESS Silver Spring, Md.	

12-1-56
6-1-56

Government of India
C. P. - 12-1-56

12-1-56

AUG 31 1956

12-1-56

12-1-56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, See [unclear] [unclear]

CERTIFICATE OF DEATH

89409

Reg. Dist. No.

8446

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown, R. F. D. # 2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle B. Last Battle		4. DATE OF DEATH Month August Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 12 Months 12 Days 14 Hours Min
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Willie Battle		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Elizabeth Battle Address Germantown, Md. R.F.D. # 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory infection DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 day DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition, since birth			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 30 , 19 56 , to Aug 30 , 19 56 , that I last saw the deceased alive on Aug 30 , 19 56 , and that death occurred at 4 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. A. Linthicum M.D. 110 E. Washington St. Rockville, Md. PHYSICIAN'S NAME (Type) W. A. Linthicum Aug 30 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
Burial	9/1/56	Lincoln Park, Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surrden ADDRESS Rockville		24a. REC'D BY REGISTRAR DATE 9/7/56	24b. REGISTRAR'S SIGNATURE Lawrence Kragtorp

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SEP 11

8463

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY						2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE M.D. b. COUNTY MONTGOMERY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN lb 5 DAYS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SAN.								d. STREET ADDRESS 10411 EWELL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Daisy		Middle F.		Last Bell		4. DATE OF DEATH		Month Aug.		Day 10		Year 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1876		9. AGE (In years last birth day) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME BENJ. F. GIBSON						14. MOTHER'S MAIDEN NAME NELLIE HUGHES											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Lillian G. Bell				Address 10411 Ewell Ave. Kensington Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary occlusion. DUE TO (c) Coronary arteriosclerosis. INTERVAL BETWEEN ONSET AND DEATH: 10 min., 10 min., ?																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Pelvis														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down in yard 10-12 days ago.													
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) Kensington Md.		(County)		(State)			
21. I certify that I attended the deceased from Aug. 5, 1956, to Aug. 10, 1956 that I last saw the deceased alive on August 10, 1956, and that death occurred at 8:00 AM, from the causes and on the date stated above.																	
ACTUAL SIGNATURE James A. Roberts				ADDRESS (Street, city or town, state) M.D. 8907 Georgia Ave. Silver Spring Md Aug 10, 1956										DATE SIGNED			
PHYSICIAN'S NAME (Type) JAMES A. ROBERTS				8907 GEORGIA AVE SILVER SPRING, MD													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-13-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland Md				22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE J.W. = Lewis Son - Washington D.C.				ADDRESS				24a. RECEIVED BY REGISTRAR DATE 8/15/56		24b. REGISTRAR'S SIGNATURE Frances Potter							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Memorandum

Sept. 2, 1956 38

Kellie Hughes

BUREAU V. S.

AUG 17 1956

RECEIVED

Washington D.C.
Bureau of Civil Control
B-13-26

8464

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>5317 Wakefield Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Ruth Mary Bertram</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-00</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Amos HARGREAVES</u>				14. MOTHER'S MAIDEN NAME <u>CORA SPENSLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CLARENCE R. BERTRAM - son</u> <u>5852 Cambridge Ave Springfield, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adeno carcinoma of ovary @ metastasis</u> 175X DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> 19 <u>55</u> , to <u>Aug</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 1</u> 19 <u>56</u> , and that death occurred at <u>1445</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Du Page Co. Illinois</u> DATE SIGNED <u>Aug 1, 1956</u> ACTUAL SIGNATURE <u>Donald G. Chman</u> M.D. <u>5707 Wisconsin Ave., Bethesda, Md.</u> PHYSICIAN'S NAME (Type) <u>Donald G. Chman - 5707 Wis. Ave., Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-Transit</u>		<u>8-4-56</u>		<u>Elm Lawn Cem</u>		<u>Du Page Co. Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md</u>		24a. REC'D BY REGISTRAR DATE <u>8-2-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Housh</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

J. A. DUNN

AUG 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68494

8415

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>Maria</u> Last <u>Blakeley</u>			4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1956</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-86</u>		9. AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Joseph Blakeley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (left parietal)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Malignant Lymphoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malignant Lymphoma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-8-1956</u> to <u>8-14-1956</u> , that I last saw the deceased alive on <u>8-14-1956</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>			ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			DATE SIGNED <u>8/14/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Churchville</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Williams</u>				24a. REC'D BY REGISTRAR <u>DATE 8/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Hunkle</u>	

RECEIVED

AUG 16 1950

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1105 Wade Avenue</u>		d. STREET ADDRESS <u>1105-WADE AVE</u>	
3 NAME OF DECEASED (Type or print) First <u>EARLEY</u> Middle <u>M</u> Last <u>BLANKENBAKER</u>		4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1956</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-71</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	9. AGE (In years last birthday) <u>85</u> yrs
10a. BIRTHPLACE (State or foreign country) <u>MADISON County, VA</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NELSON BLANKENBAKER</u>		14. MOTHER'S MAIDEN NAME <u>MARY FRANCES EARLY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>RUTH M. BLANKENBAKER</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CHRONIC GLOMERULONEPHRITIS</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>THREE DAYS</u> <u>TEN YEARS</u> <u>FIFTEEN YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>FEB</u> 1956, to <u>AUGUST 12</u> 1956, that I last saw the deceased alive on <u>AUGUST 12</u> 1956, and that death occurred at <u>440 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Rasmussen</u> M.D.		DATE SIGNED <u>Aug 12, 1956</u>	
PHYSICIAN'S NAME (Type) <u></u>		ADDRESS (Street, city or town, state) <u>310 W. MONTGOMERY AVE</u> <u>ROCKVILLE, MD.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/14/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wisconsin Ave.</u>		24a. REC'D BY REGISTRAR <u>8-14-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 16 1946

BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 8465 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

08496
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Tazewell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>61 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bluefield</u>			
f. STREET ADDRESS <u>Route 1, Box 464</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>Edison</u> Last <u>Bowman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 27, 1923</u>	
9. AGE (In years last birthday) yrs. <u>32</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Sidney I. Bowman</u>			
14. MOTHER'S MAIDEN NAME <u>Gertrude Bryerson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes II</u>			
16. SOCIAL SECURITY NO <u>224-28-7079</u>				17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas septicaemia</u> DUE TO <u>to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pseudomonas of Right foot (cellulitis)</u> (c) <u>Acute Lymphatic Leukemia</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 14, 1956</u> , to <u>August 14, 1956</u> , that I last saw the deceased alive on <u>August 14, 1956</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Thomas Waldman, M. D.</u>				DATE SIGNED <u>8/15/56</u>			
ACTUAL SIGNATURE <u>Thomas Waldman</u>				M.D. <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Thomas Waldman, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Transit</u>		22b. DATE THEREOF <u>8/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tazewell County Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 15 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

BUREAU W.D.

MAY 17 1956

RECEIVED

8466
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURNT MILLS HILLS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURNT MILLS HILLS	
c. LENGTH OF STAY in 1b 19½ yrs.		d. STREET ADDRESS 10,701 HARPER AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,701 HARPER AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle NORMAN Last BRADLEY		4. DATE OF DEATH Month AUGUST Day 7 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/89
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY-AT-LAW - retired		10b. KIND OF BUSINESS OR INDUSTRY SOUTH CAROLINA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM OSCAR BRADLEY		14. MOTHER'S MAIDEN NAME LAURA GRIER MOFFATT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW#1		16. SOCIAL SECURITY NO. 577-01-0842	
17. INFORMANT Mrs. Frances A. Bradley, 10,701 Harper Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 1947, to 7 Aug , 1956, that I last saw the deceased alive on April , 1956, and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE William D. Aud M.D. 9046 Leesville Rd PHYSICIAN'S NAME (Type) WILLIAM D. AUD Silver Spring			
22a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/10/56	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) _____ (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner G. Humphrey		24a. REC'D BY REGISTRAR DATE 8/14/56	24b. REGISTRAR'S SIGNATURE Frances A. Bradley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 16 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8467
CERTIFICATE OF DEATH

08418

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5601 Madison St.				d. STREET ADDRESS 5601 Madison St.			
3. NAME OF DECEASED (Type or print) First MARGARET Middle LORRAINE Last BRITT				4. DATE OF DEATH Month August Day 24 , Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-11		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Henry C. Plummer				14. MOTHER'S MAIDEN NAME Rosabell Kanode			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John H. Britt-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Cardiac Failure IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Abdominal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to carcinoma of gall bladder primary with metastasis (c) with metastasis							INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 2 days 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-21- 1956 , to 8-24- 1956 , that I last saw the deceased alive on 8-24- 1956 , and that death occurred at 11:50 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5029 Bethesda Ave, Beth. Md DATE SIGNED Bessie M. Thorn							
ACTUAL SIGNATURE Herbert Martyn Jr. M.D. 5029 Bethesda Ave, Beth. Md							
PHYSICIAN'S NAME (Type) Herbert Martyn, Jr. 5029 Bethesda Ave., Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-56		22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cem.		22d. LOCATION (City, town, or county) (State) Gaithersburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR 25-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thorn			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08499

8468

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 116 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1325 13th Street, N.W. Apt. # 3	
3. NAME OF DECEASED (Type or print) First Alyce Middle Gwendolyn Last Brown		4. DATE OF DEATH Month August Day 19 Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 18, 1918
9. AGE (n years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock girl		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Wade		14. MOTHER'S MAIDEN NAME Susie Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 578-20-1718	
17. INFORMANT The Clinical Center		Address Bethesda 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
DUE TO (b) Arteriolonephrosclerosis			
DUE TO (c) Essential Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Staphylococcal Septicemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 25, 1956 , to August 19, 1956 , that I last saw the deceased alive on August 19, 1956 , and that death occurred at 7:20 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 820 156 DATE SIGNED			
ACTUAL SIGNATURE John Davidson		M.D. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) John Davidson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) urial		22b. DATE THEREOF 8.23.56	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		ADDRESS 1820 9th St., N.W. Washington, D. C.	
24a. REC'D BY REGISTRAR 16 22 1956		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

BUREAU V. S.

AUG 22 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8469 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88410
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>				d. STREET ADDRESS <u>8009 Maple Ridge Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8009 Maple Ridge Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Grac</u> First <u>William</u> Middle <u>Buchanan</u> Last				4. DATE OF DEATH <u>Aug</u> 25 19 <u>56</u> Month Day Year			
5. SEX <u>48</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-1908</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Exam.</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wm Buchanan</u>		14. MOTHER'S MAIDEN NAME <u>Adelle Grac</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Verna Buchanan (wife)</u>		Address <u>Shiloh ex. Stn 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MI</u> DUE TO (c) <u>MI</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8-25-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Patuxent George Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u> ADDRESS <u>3821-14th NW Wash D.C.</u>				24a. REC'D BY REGISTRAR <u>8-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used for burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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AUG 30 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8411

CERTIFICATE OF DEATH

Reg. Dist. No. 215

Items 13, 14: 8470 2039-20-56C

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Bertles Last BURNS				4. DATE OF DEATH Month August Day 28 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 August 1956		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David M. BURNS				14. MOTHER'S MAIDEN NAME Katherine HUMER Kate Bertles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) David Burns, (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CENTRAL NERVOUS SYSTEM DAMAGE 751V DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MENINGOMYLOCLE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 31 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 August , 19 56 , to 28 August , 19 56 , that I last saw the deceased alive on 28 August 1956 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-29-56							
ACTUAL SIGNATURE Daniel Shuptal		PHYSICIAN'S NAME (Type) DANIEL SHUPTAL, LT. MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-31-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 8-29-56	
				24b. REGISTRAR'S SIGNATURE Brady E. Parrelly			

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CERTIFICATE OF DEATH

08412

Reg. Dist. No. 215

8471

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d STREET ADDRESS 513 Market Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Henry		First Henry		Middle DAVID		Last BYARD	
4. DATE OF DEATH Month August Day 22 Year 19 56							
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 1929	9 AGE (In years last birthday) yrs 27	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Byard				14. MOTHER'S MAIDEN NAME Ruth Masten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1-16-47 to 2-28-54		16. SOCIAL SECURITY NO. 140 20 2609		17. INFORMANT Address (Sister) Mrs. Betty E. Barcklow (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spinal tumor (post-op) DUE TO Pinealoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 3 days 3+ yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 2 Aug. 1956 , to 22 Aug. 1956 , that I last saw the deceased alive on 22 Aug. 1956 , and that death occurred at 7:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.W. Mackie, CDR, MC, USN				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-23-56			
PHYSICIAN'S NAME (Type) R.W. Mackie, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md. 8-23-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 27 Aug. 1956	22c. NAME OF CEMETERY OR CREMATORY Hightstown Cemetery		22d. LOCATION (City, town, or county) (State) Hightstown, New Jersey			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 8-23-56 24b. REGISTRAR'S SIGNATURE Gray E. Parrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUG 1 1956

RECEIVED
JUL 24 1956

8472
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mich.</u> b. COUNTY <u>Washtenaw</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>322 John Street</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>May</u> Middle <u>Cannon</u> Last		4. DATE OF DEATH <u>Aug. 6</u> Month <u>6</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Ann Arbor, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Field</u>		14. MOTHER'S MAIDEN NAME <u>Grace Jewell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Grace Burroughs</u> Address <u>10118 Cedar Lane, Kensington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Chronic Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-6-56</u> , 19 <u>56</u> , to <u>8-6-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-6-56</u> , 19 <u>56</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Morris Perry</u> M.D.		ADDRESS (Street, city or town, state) <u>1607 Georgia Ave Silver Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		DATE SIGNED <u>8-6-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	22b. DATE THEREOF <u>8-6-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washtenaw Co. Mich.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda Md</u>		24a. REC'D BY REGISTRAR <u>8-10-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURTON A. E.

1956

W. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 rilmG202 8-1-11 et

CERTIFICATE OF DEATH

08414

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Minn.</u> b. COUNTY <u>Meeker</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cosmos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8000 Greenwood Ave</u>				d. STREET ADDRESS <u>home</u>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Christine</u> Last <u>Carlson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 27, 1864</u>	
9. AGE (In years last birthday) <u>91</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u> Hours <u>93</u>		IF UNDER 24 HRS Months <u>9</u> Days <u>12</u> Hours <u>93</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sven Carl Magnusson</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Swenson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Linea Bunch (daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Arteriosclerosis, Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 yrs.</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pernicious Anemia - 25 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1</u> , 19 <u>56</u> to <u>Aug. 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 16</u> , 19 <u>56</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Park Md.</u> DATE SIGNED <u>8/19/56</u>					
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>		22b. DATE THEREOF <u>Aug 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u> Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cosmos, Minnesota</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll Dr NW DC</u>		24a. REC'D BY REGISTRAR <u>J. Arthur Walters</u>		24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>	

BUREAU V. S.

AUG 10 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8473

CERTIFICATE OF DEATH

Reg. Dist. No.

084154
274

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14,619 COLESVILLE ROAD		d. STREET ADDRESS 14,619 COLESVILLE ROAD	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LELA REBECCA CARTER		4. DATE OF DEATH Month Day Year AUGUST 3 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 12, 1872
9. AGE (In years last birthday) yrs 84		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER WORKED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) TEXAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT M. CARTER		14. MOTHER'S MAIDEN NAME REBECCA S. KERNS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MISS SUSIE E. CARTER, 1841 Columbia Rd., N. W.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis.</u> DUE TO (c) <u>Right Hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 years 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1, 1951, to 8/3, 1956 that I last saw the deceased alive on 8/3, 1956, and that death occurred at 5 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. W. BIRD M.D. 8/9/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/6/56	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey, ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 8/2/56	
24b. REGISTRAR'S SIGNATURE Frances Potter			

STANDARD V. 1

1951 1954

REAR VIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08416
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chase & Wisconsin Ave's.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4500 Gladwyn Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROY C CATLETT</u>			4. DATE OF DEATH Month Day Year <u>August 29, 19 56</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 2-1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days <u>4 27</u>	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. Car Opr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit</u>		11. BIRTHPLACE (State or foreign country) <u>West. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harrison Catlett</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Wife</u> <u>Mabel L. Catlett</u> Address <u>Above Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4-10-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>9-1-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>			24a. REC'D BY REGISTRAR <u>8/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Beaumont Thompson</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BONNARD A. E.

1956



8475

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 21601 BALTIMORE RD. TIGTON'S NURSING HOME			
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN BAUGHER CHISOLM				4. DATE OF DEATH Month Day Year AUG 31 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/14/1866	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH BAUGHER				14. MOTHER'S MAIDEN NAME EMILY BEVAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. ROBERT CHISOLM-SON Address 812 PARK AVE., BALTIMORE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None known				INTERVAL BETWEEN ONSET AND DEATH Several weeks.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 31, 1956 to Aug. 31, 1956 , that I last saw the deceased alive on Aug. 31, 1956 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Chem Chase Rd., Baltimore, Md. DATE SIGNED 8/31/56							
ACTUAL SIGNATURE George A. Gray, Jr. PHYSICIAN'S NAME (Type) George A. Gray, Jr.				M.D. Chen Chase Rd.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/1956		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. BURIAL DIRECTOR'S SIGNATURE Wm. J. Thompson				ADDRESS 104 Chem Chase Rd., Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Bessie Thompson	
				24a. REC'D BY REGISTRAR DATE 9/4/56			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

5 1956

RECEIVED

Item 8 File #203 9-14-56 et

68418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANDOVER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9167 BROOKEVILLE ROAD		d. STREET ADDRESS OAK ST., CHEVERLY GARDENS	
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last COFFEY		4. DATE OF DEATH Month AUGUST Day 30 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18th JULY 12, 1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY PENNA. RAILROAD	11. BIRTHPLACE (State or foreign country) FISHERVILLE, VIRGINIA
13. FATHER'S NAME ALEXANDER COFFEY		14. MOTHER'S MAIDEN NAME SARAH REBECCA CAMPBELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 716-03-1111	
17. INFORMANT Mrs. Emelene L. Coffey, Oak St., Cheverly Gardens Landover, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHIOGENIC CARCINOMA WITH DUE TO (c) BRAIN METASTASES INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 15 Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 15, 1956 to AUG. 30, 1956 , that I last saw the deceased alive on AUG. 29, 1956 , and that death occurred at 8:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3131-16th ST. N.W. WASHINGTON 10, D.C. DATE SIGNED Basil Blumenthal			
ACTUAL SIGNATURE Basil Blumenthal		M.D. 3131-16th ST. N.W. WASHINGTON 10, D.C.	
PHYSICIAN'S NAME (Type) BASIL BLUMENTHAL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/1/56	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DATE 9-5-56	24b. REGISTRAR'S SIGNATURE Frances C. Trotter

BUREAU V. 8

SEP 7 1956

RECEIVED

8417

CERTIFICATE OF DEATH

Reg. Dist. No. 08419 3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>Ethel</u> Last <u>Cole</u>		4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1881</u>
9. AGE (In years, last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>William Lightfoot</u>		14. MOTHER'S MAIDEN NAME <u>Anna Blades</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Pl's Hospital Record</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>+ Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 June 1956</u> to <u>12 Aug., 1956</u> , that I last saw the deceased alive on <u>12 Aug., 1956</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.		ADDRESS (Street, city or town, state) <u>8801 Colesville Road</u> DATE SIGNED <u>12 Aug. '56</u>	
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold MD.</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT & BURIAL</u>		22b. DATE THEREOF <u>8/14/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GRANDVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>GARY, SOUTH DAKOTA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar E. Murphy</u>		ADDRESS <u>8434 Ga Ave.</u>	
24a. REC'D BY REGISTRAR <u> </u> DATE <u>8/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Wood</u>	

BUREAU V. S.

AUG 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8477

CERTIFICATE OF DEATH

18420

Reg. Dist. No. 217

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Green Ridge" Columbia Pike</u>		d. STREET ADDRESS <u>"Green Ridge" Columbia Pike</u>	
3 NAME OF DECEASED (Type or print) <u>Edgar T. Conley</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professional Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>	9. AGE (In years last birthday) <u>82</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Fairland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Wm. Conley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Larrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Clare M. Conley, "Green Ridge" Columbia Pike Fairland, Maryland</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>22</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 am</u> <u>noon</u> <u>noon</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3/11</u> , 19 <u>57</u> , to <u>8/20</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>8/19</u> , 19 <u>56</u> , and that death occurred at <u>4 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring</u> <u>8/20/56</u> ACTUAL SIGNATURE <u>J. W. Bird</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Episcopal Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-22-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Lester B. Towler</u>		24c. REGISTRAR'S SIGNATURE <u>Lester B. Towler</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

AUG

RECEIVED

8478

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>RTH 2</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Cooper</u>				4. DATE OF DEATH <u>August 27 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 12/56</u>	
9. AGE (In years, last birthday) <u>16</u>		IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min <u>16</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Edward Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Betty Rebecca Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Gastroenteritis of the newborn</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks (4)</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 12, 1956</u> to <u>Aug 27, 1956</u> , that I last saw the deceased alive on <u>Aug 27, 1956</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert O. Warthen</u>				DATE SIGNED <u>Suburban Hospital - Attending Staff 8-27-56</u> (Office Room, 4th, MD)			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		22d. LOCATION (City, town, or County) (State) <u>Rockville, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sunden</u>				ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>8-1-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU No. 1

SEP 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08422

Reg. Dist. No. 212

8479

1. PLACE OF DEATH a. COUNTY <u>Dickerson Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>				c. LENGTH OF STAY IN 1b <u>D O A</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Big Woods Road</u>				d. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence William Corum</u>				4. DATE OF DEATH Month Day Year <u>Aug 10, 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1/17/1887</u>	
9. AGE (in years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>usa</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Dorothy Hallman, Sellman, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>storing the underlying cause lost.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead near home</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Sellman, Md.</u>	
23. FLUENT DIRECTOR'S SIGNATURE <u>Robert J. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24. REC'D BY REGISTRAR <u>Aug 15 1956</u>	
				25. REGISTRAR'S SIGNATURE <u>Chas. Edgins</u>			

THIS MEDICAL EXAMINER'S CERTIFICATE OF DEATH shall be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 15 1956

RECEIVED

8480

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NELL BEATRICE CRAWFORD		4. DATE OF DEATH Month Day Year AUG. 4 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 24, 1921
9. AGE (In years last birthday) 34 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Electronics	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DREWIE James Tolliver		14. MOTHER'S MAIDEN NAME Lilly Chambers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 230-36-9046	
17. INFORMANT Robert Tolliver - brother		Address 12322 Denny Rd. SS Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fulminant Infectious Hepatitis DUE TO — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO — (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/25 , 19 56 , to 8/4 , 19 56 , that I last saw the deceased alive on 8/4 , 19 56 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE Charles Farwell MD		ADDRESS (Street, city or town, state) Wheaton, Md.	
PHYSICIAN'S NAME (Type) CHARLES FARWELL		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/8/56	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 8-9-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. J.

1956

CERTIFICATE OF DEATH

Reg. Dist. No.

118424

8481

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508 Johnson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle STRAYER Last CUKELA		4. DATE OF DEATH Month August Day 10 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 4 Days 20 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank Senicar - Nephew		Address 5508 Johnson Ave. Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF LEFT BREAST DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 17 YEARS 2+ YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION, OLD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SUMMER, 1957 to AUG, 1956 , that I last saw the deceased alive on 8/10, 1956 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles J. Savarese Jr. (M.D.)		ADDRESS (Street, city or town, state) 4801 BATTERY LANE	
PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE JR. BETHESDA MD.		DATE SIGNED 8/10/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphreys ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 8-14-56 24b. REGISTRAR'S SIGNATURE Bessie M. Humphreys	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 16 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08425

CERTIFICATE OF DEATH

Reg. Dist. No. 216

8482

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltersda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>6 days 18 hrs</u>		d. STREET ADDRESS <u>10105 LORAIN AVENUE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Clinton Cushman Sr.</u>		4. DATE OF DEATH Month Day Year <u>8-16 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-03</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maxwell & Tennyson Drug Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES R. CUSHMAN</u>		14. MOTHER'S MAIDEN NAME <u>Anne RYAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1919-26</u>		16. SOCIAL SECURITY NO. <u>577-05-9122</u>	
17. INFORMANT <u>Howard C. Cushman, Jr.</u> Address <u>10105 LORAIN AVE. SSS, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 440X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>15-20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-9</u> 19 <u>56</u> , to <u>8-16</u> 19 <u>56</u> , that I last saw the deceased alive on <u>8-15</u> 19 <u>56</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. G. Hall</u>		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u> DATE SIGNED <u>8/14/56</u>	
PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-18-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>1435 Spring St. Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>8-18-56</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DONAU V. N.

1956

DELIVERED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08426

8483

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 mos 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle William Last DAILEY				4. DATE OF DEATH Month August Day 29 Year 1956			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 January 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood Dealer				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Dennis DAILEY				14. MOTHER'S MAIDEN NAME Mary Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. 218 20 0081		17. INFORMANT (Sister) Mrs. Anna Black 4915 "R" St., S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x DUE TO Penitonal Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma Head of Pancreas (c) unk.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 21 June 1956 to 29 August 1956 , that I last saw the deceased alive on 29 August 1956 , and that death occurred at 1:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE T. S. Dunn Jr.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) T.S. DUNN, JR. LT, MC, USN				DATE SIGNED 8-29-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-31-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home, 517 11th St., S.E. Wash. D.C.				24a. REC'D BY REGISTRAR 8-29-56		24b. REGISTRAR'S SIGNATURE Mary E. Cassel	

BUREAU V. O.

AUG 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8418

CERTIFICATE OF DEATH

Reg. Dist. No.

88427
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7008 Woodland Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jahis</u> Middle <u>Rudolf</u> Last <u>Dance</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-07</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>31</u> Days <u>31</u> Hours <u>19</u> Min.	IF UNDER 24 HRS Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watch Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Latvia</u>	
13. FATHER'S NAME <u>Martin Dance</u>				14. MOTHER'S MAIDEN NAME <u>Ann Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U</u>		16. SOCIAL SECURITY NO. <u>27-10</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asperia + Malnutrition</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Septicemic colic fistula</u> DUE TO (c) <u>Carcinoma of Stomach</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 month</u> <u>15 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1953, to <u>Aug 31</u> , 1956, that I last saw the deceased alive on <u>Aug 31</u> , 1956, and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lyle Williams</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8700 Calzaville Rd Silver Spring 8/31/56</u>			
PHYSICIAN'S NAME (Type) <u>Lyle Williams</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Georhan - Walters</u>				ADDRESS <u>254 Cornell St</u>		24a. REC'D BY REGISTRAR DATE <u>9/1/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Walter R. Dick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 1956

DE A-5-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8484

CERTIFICATE OF DEATH

08428

Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>5314-42nd Place, N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>De Grummond</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Sears</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daughter - Margaret De Grummond</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> DUE TO <u>Coronary artery heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ben arteriosclerosis. Hypertension</u> (c) <u>Acute gangrenous appendicitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>6 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-24</u> , 19 <u>56</u> to <u>Aug 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-2</u> , 19 <u>56</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Brennan</u> M.D.		ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u>	
DATE SIGNED <u>8-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chueh Fung</u>		ADDRESS <u>5103 7th Ave N.W.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. 3

AUG 14 1956

RECEIVED

8485

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN IB <u>26 minutes</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills Park</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Bethesda, Md.</u>			
d. STREET ADDRESS <u>6419 Cedar Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>(n)</u> Last <u>De Mattia</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 Aug. 1956</u>	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Mins.		26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Edmond Edgar De Mattia</u>			
14. MOTHER'S MAIDEN NAME <u>Endla Valgerist</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>- - -</u>				17. INFORMANT <u>Father</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATURITY</u> <u>116X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) <u>20 WKS GESTATION</u> 26				INTERVAL BETWEEN ONSET AND DEATH <u>26</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>10 August</u> , 19 <u>56</u> , to <u>10 August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 August</u> , 19 <u>56</u> , and that death occurred on <u>09:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel Shuptar</u> M.D.				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>			
DATE SIGNED <u>8-11-56</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>11 August 1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Virginia</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>			
ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>Mary E. Parrell</u>			
24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrell</u>				DATE <u>8-11-56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 14 1950

BUREAU V. S.

8486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

MONT

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town)

TOWN SILVER SPRING

HOSPITAL OR INSTITUTION OR STREET ADDRESS

1401 HIGHLAND DR.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MD

COUNTY

MONT

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

SILVER SPRING

STREET ADDRESS

1401 HIGHLAND DR.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

WARDWELL C

DEXTER

4. DATE OF DEATH:

(Month)

(Day)

(Year)

8-1-56

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

8. DATE OF BIRTH:

1-24-1899

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

57 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

OWNER

10b. KIND OF BUSINESS OR INDUSTRY:

PARKING LOT

11. BIRTHPLACE (State or foreign country):

BAYON, N.J.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

WILLIAM DEXTER

14. MOTHER'S MAIDEN NAME:

ELIZABETH V. MACMILLAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Yes

WWI

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Ruth B. Dexter 1401 Highland Dr. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

DUE TO

(a) Bronchogenic carcinoma of lung (at)

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(c)

Interval Between Onset And Death

about 1 yr

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertension

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from

1947 to 57, 1956, that I last saw the deceased

alive on 7/30, 1956, and that death occurred at 9 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8-2-56

Francis Satter 1706 Palmyra N.W.-D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 5 1956

RECEIVED

08431

8419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen & Hospital</u>				d. STREET ADDRESS <u>720 Peabody St N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>LINA K. DREIFUS</u>				4. DATE OF DEATH <u>August 16 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-1876</u>	
9. AGE (In years last birthday) <u>80 yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Israel Koschland</u>				14. MOTHER'S MAIDEN NAME <u>Esther Wolf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the gall bladder</u> DUE TO <u>cardiovascular insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>2 19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 7th, 1956</u> , to <u>August 16, 1956</u> , that I last saw the deceased alive on <u>August 16, 1956</u> , and that death occurred at <u>8:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Veronika Troost</u>				ADDRESS (Street, city or town, state) <u>10401 New-Hampshire Ave.</u>			
PHYSICIAN'S NAME (Type) <u>VERONIKA TROOST</u>				DATE SIGNED <u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>W. Hyattsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kanyaneky & Sons</u>				ADDRESS <u>3501-14th St NW</u>		24a. REC'D BY REGISTRAR <u>DATE 8/18/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

BUREAU V. S.

AUG 20 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

8487

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>95 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Arlington</u>				d. STREET ADDRESS <u>4631 24th Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mathilde</u> Middle <u>Ann</u> Last <u>DREITH</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 March 1905</u>	
9. AGE (In years last birthday) yrs. <u>51</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Brueggeman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT (Husband) <u>Joseph F. Dreith (Same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Bronchogenic with metastasis</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 May 1956</u> to <u>15 August 1956</u> , that I last saw the deceased alive on <u>15 August 1956</u> and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>8-16-56</u>							
ACTUAL SIGNATURE <u>R. J. Mc Carthy</u> M.D.							
PHYSICIAN'S NAME (Type) <u>R. J. MC CARTHY, CDR, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Harrison</u> ADDRESS <u>Virginia</u>				24a. REC'D BY REGISTRAR <u>8-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>	
IVES Funeral Home 2847 Wilson Blvd, Arlington, DATE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 20 1956

BUREAU V. B.

8488

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4mos.22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle Joseph Last EALER		4. DATE OF DEATH Month August Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 April 1956
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR: Months 22 Days 4 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul Joseph EALER		14. MOTHER'S MAIDEN NAME Alyce AYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (Father) Paul Joseph EALER		Address (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. 44 (b) Congenital cyanotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 1/2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 April , 1956, to 25 August , 1956, that I last saw the deceased alive on 25 August , 1956, and that death occurred at 2:55A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-25-56			
ACTUAL SIGNATURE John H. Mazur		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) John H. MAZUR, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-28-56	22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 8-25-56		24b. REGISTRAR'S SIGNATURE Harry E. Caswell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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11/11/11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V5. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8489 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08434

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN 1b 15 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Airy (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General		d. STREET ADDRESS RFD #1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Ellsworth Last Egoff		4. DATE OF DEATH Month 8/16/56 Day 19 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/1908
9. AGE (in years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 5 Days 3	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Pa	11. BIRTHPLACE (State or foreign country) Pa
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dan Egoff	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-05-5755		17. INFORMANT Mary Egoff (wife) Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage Fracture of skull DUE TO (b) Fracture of skull DUE TO (c) Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) passenger in auto accident			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) passenger in auto accident		20c. TIME OF INJURY Month, Day, Year 8/16/56 Hour 4:38 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md R- 108	
20f. (City or town) Etchison		(County) Montg (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-20-1956	
22c. NAME OF CEMETERY OR CREMATORY New Market		22d. LOCATION (City, town, or county) (State) New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Bertus L. Luecke	

2019

RECEIVED

AUG 20 1956

BUREAU V. S.

8420

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		STATE MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Takoma Park		25 days		TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital				STREET ADDRESS (If rural give location) 1301 Longfellow St., N.W.			
3. NAME OF DECEASED (First) (Middle) (Last) Katherine May Ehlers				4. DATE OF DEATH (Month) (Day) (Year) August 30 19 56			
5. SEX F	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 4, 1893	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Emmons				14. MOTHER'S MAIDEN NAME Alice Pritthead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) HE Cirrhosis, hepatic with ascites						2 months	
ANTECEDENT CAUSE(S) DUE TO (B) congestive heart failure (myocardial)						1 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arthritis, hypertrophic							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. 1954		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 29 , 19 56 , to Aug 30 , 19 56 , that I last saw the deceased alive on Aug 29 , 19 56 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.							
SIGNATURE Samuel G. Williams M.D.		ADDRESS (Street, city, town, state) 249 Missova Ave NW		DATE SIGNED 8/30/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/1/56		NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
RECEIVED BY REGISTRAR AUG 31 1956		REGISTRAR'S SIGNATURE J. Williams		25. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington 9, D.C.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8490

CERTIFICATE OF DEATH

08436

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>5 mos. 23 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>7302 Maple Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Arthur</u> Last <u>FLOOD</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1956</u>					
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 Nov. 1896</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign Service Officer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>James Flood</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Meeks</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Janet M. FLOOD (Wife), Same As #2)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic cancer brain</u> DUE TO <u>Carcinoma pancreas + metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>2 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>28 Feb.</u> , 19 <u>56</u> , to <u>21 Aug.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>21 Aug.</u> , 19 <u>56</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>8-21-56</u> ACTUAL SIGNATURE <u>W. H. Druckemiller</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>W.H. Druckemiller, CAPT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u> <u>R.A. Pumphrey Funeral Home, 7557 Wisc. Ave.</u>		24a. REC'D BY REGISTRAR <u>8-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>May E. Carroll</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 22 1956
BUREAU V. S.

8421

CERTIFICATE OF DEATH

18437

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>4 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Son & Hosp.</i>				e. STREET ADDRESS <i>3136 Copperthwaite Lane NW</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Gertrude Waring Foote</i>				4. DATE OF DEATH Month Day Year <i>Aug. 10 1956</i>			
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 21 1914</i>	9. AGE (In years last birthday) <i>42</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Bundy, Mr John French</i>				14. MOTHER'S MAIDEN NAME <i>Waring, Gertrude</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> DUE TO (b) <i>Primary Carcinoma (Left breast)</i> DUE TO (c) <i>Two feet (?)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>Armed</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-6-</i> 1956, to <i>8-10-</i> 1956, that I last saw the deceased alive on <i>8-10-</i> 1956, and that death occurred at <i>11⁰⁰</i> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert A Hare</i> M.D.				ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i>		DATE SIGNED <i>8/10/56</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8/13/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>QUAKER CEMT.</i>		22d. LOCATION (City, town, or county) (State) <i>FT. BELVOIR, VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>BIRCH FUNERAL Home</i> ADDRESS <i>3834 M ST NW WASH. DC.</i>				24a. REC'D BY REGISTRAR <i>8/13/56</i>		24b. REGISTRAR'S SIGNATURE <i>J. H. H. H.</i>	

MEDICAL CERTIFICATION

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RECEIVED

AUG 14 1930

BUREAU V. 3

CERTIFICATE OF DEATH

Reg. Dist. No. 216

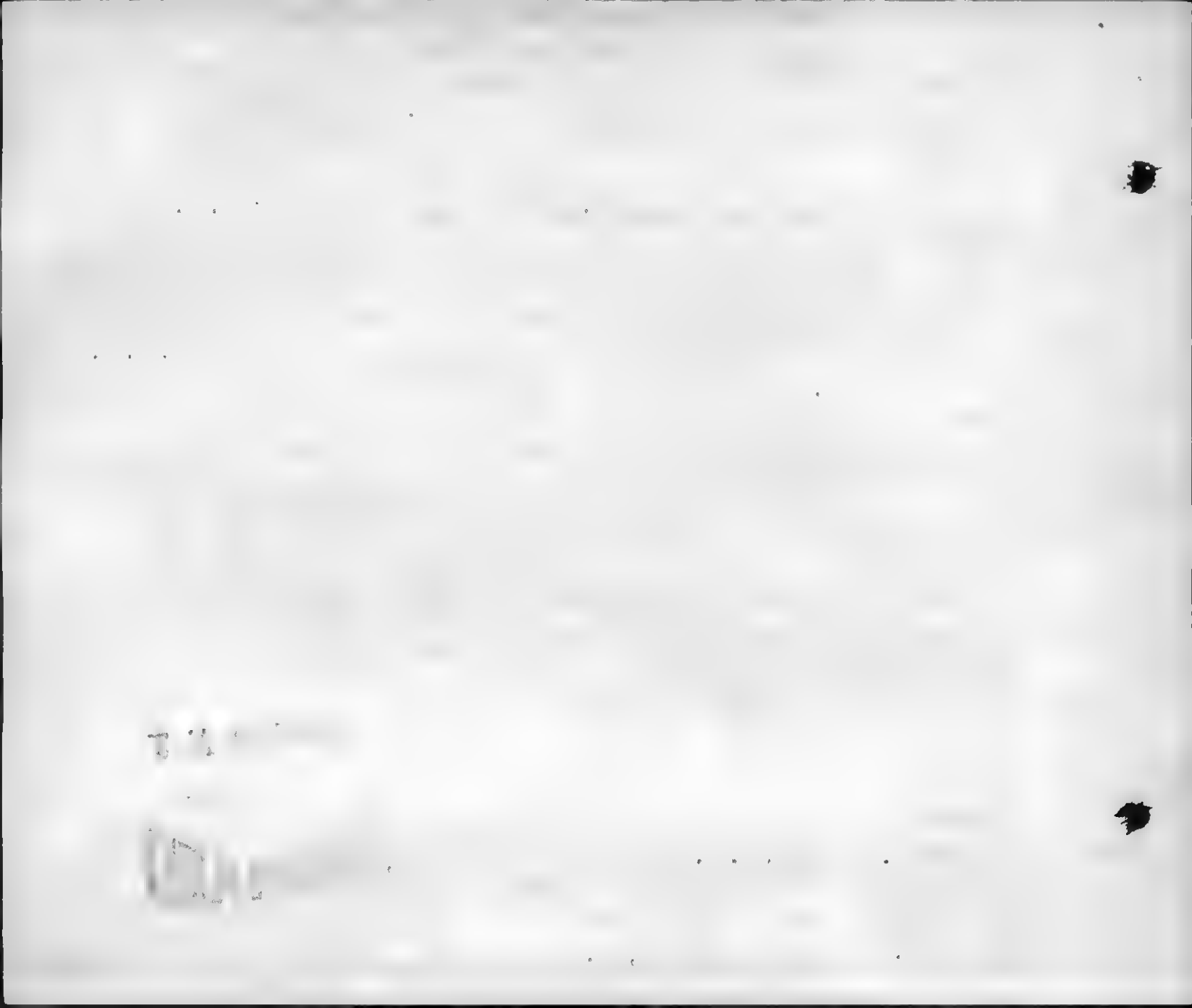
18438

8491

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>5213 Chevy Chase Parkway, N. W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Taylor</u> Last <u>Forschner</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1951</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>1</u> Min <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minor Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>Richard A. Forschner</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>The Medical Record</u>				Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell, rose, lung carcinoma, metastatic to brain</u> DUE TO <u>2-4-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>thrombocytopenia</u> DUE TO (c) <u>Acute lymphatic leukemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>True meningoencephalopathy</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>1 hr</u> <u>15 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Bethesda</u>				(County) <u>Montgomery</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>July 5, 1956</u> , to <u>August 21, 1956</u> , that I last saw the deceased alive on <u>August 21, 1956</u> , and that death occurred at <u>3:04 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center, Bethesda 14, Maryland</u> DATE SIGNED <u>8/21/56</u>							
ACTUAL SIGNATURE <u>S. Weissman</u> M.D. <u>The Clinical Center</u> NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
PHYSICIAN'S NAME (Type) <u>S. Weissman, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Transit</u>		22b. DATE THEREOF <u>8/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bronx, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey-Bethesda, Md.</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-23-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

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CERTIFICATE OF DEATH

Reg. Dist. No.

88439
223

8422

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 mos. 3 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		e. STREET ADDRESS <u>3208 Oliver St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lyla</u> Middle <u>Christine</u> Last <u>Fowle</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1899</u>
9. AGE (If years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't - U.S.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Keller</u>		14. MOTHER'S MAIDEN NAME <u>Julia Yeaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Charts + Records - Washington San. + Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Carcinomatosis with</u> DUE TO <u>generalized metastases to</u> <u>cerebrum & both lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(2) Primary Carcinoma Left breast</u> (c) <u>(3) Pathological fractures both humeri secondary to metastases of carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Undetermined</u> <u>4 years</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 17, 1956</u> to <u>Aug 28, 1956</u> , that I last saw the deceased alive on <u>Aug 27, 1956</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L Ball</u>		ADDRESS (Street, city or town, state) <u>7835 Eastern Ave, Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>George L Ball</u>		DATE SIGNED <u>Aug 29, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey,</u>		24. REG'D BY REGISTRAR <u>AUG 31 1956</u>	
ADDRESS <u>SILVER SPRING, MD</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Ball</u>	

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JOHN A. Y. S.

APR 4 1956

RECEIVED
APR 4 1956

CERTIFICATE OF DEATH

Reg. Dist. No.

24

8492

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Rest Home		d. STREET ADDRESS 714 Allison St. N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche M. French		4. DATE OF DEATH Month Day Year Aug. 9, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1867
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mathew H. McCon		14. MOTHER'S MAIDEN NAME Anna M. Shatzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 714 Allison St N. W.	
17. INFORMANT Buelah M. Sehorn		Address 714 Allison St N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary Thrombosis 420.1 DUE TO Advanced Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Diabetes DUE TO Diabetes (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs 30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Preston, Iowa	
21. I certify that I attended the deceased from July 27, 1956 , to August 9, 1956 , that I last saw the deceased alive on August 9, 1956 , and that death occurred at 8:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Daughin M.D.		ADDRESS (Street, city or town, state) 934 E. 14th St. N. W.	
PHYSICIAN'S NAME (Type) James H. Daughin		DATE SIGNED 8-9-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 12, 1956	22c. NAME OF CEMETERY OR CREMATORY Preston	22d. LOCATION (City, town, or county) (State) Preston, Iowa
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Georgia Ave. Wash. D. C.	
24a. REC'D BY REGISTRAR 8/14/56		24b. REGISTRAR'S SIGNATURE James H. Daughin	

MEDICAL CERTIFICATION

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RECEIVED

AUG 16 1956

BUREAU V. 3

8493

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>3 hours</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH DC</u> <u>Washington</u>				d. STREET ADDRESS <u>4696 Homer Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>FUNK</u>				4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1956</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-56</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u></u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Donald Lee FUNK</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Buell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Donald Lee Funk (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity @ 22 wks.</u> DUE TO <u>Gestation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A telecystosis</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>18 Aug.</u> <u>1956</u> , to <u>16 Aug.</u> <u>1956</u> , that I last saw the deceased alive on <u>18 Aug.</u> <u>1956</u> , and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Matthews</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>			
DATE SIGNED <u>8-20-56</u>							
PHYSICIAN'S NAME (Type) <u>W.S. Matthews, CDR, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-22-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clearspring Cemetery</u>	22d. LOCATION (City, town, or county)	(State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bast Funeral Home Boonsboro, Maryland</u>				ADDRESS			
24a. REC'D BY REGISTRAR DATE <u>8-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Carroll</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 21 1900

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

88442

8494 CERTIFICATE OF DEATH

Item 13, Form G201, 8/22/56 bh

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE XXX D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN ROCKVILLE PIKE		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN WASHINGTON, D.C.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS CONGRESSIONAL MANOR SANITARIUM 12201 ROCKVILLE PIKE				ADDRESS 3226-CHESTNUT STREET, N.W.		(If rural give location)	
3. NAME OF DECEASED (Type or Print) PEARL M. GADDES S				4. DATE OF DEATH (Month) (Day) (Year) AUGUST 17 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 2-9-1878		9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MEMPHIS, TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Marshall				14. MOTHER'S MAIDEN NAME -----MARSHALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS JACK N. PAISLEY- 3226-CHESTNUT STREET, N.W.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cerebral Hemorrhage		ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 Mo			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C) 2608		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes		5 Yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. M. P.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1945, 19 to Aug 17, 1956, that I last saw the deceased alive on Aug 15, 1956, and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE David Hays				DATE SIGNED 8/17/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8/20/1956		NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. RECEIVED BY REGISTRAR 20 1956		REGISTRAR'S SIGNATURE Frances Potter		25. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG CO. 1300 N. STREET, NW			
DATE				WASHINGTON, D.C.			

RECEIVED

AUG 20 1956

BUREAU V. 2

8495

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 8yr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 11 Park Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Edith Middle Mobley Last Gaithersburg				4. DATE OF DEATH Month Aug Day 6 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ay 4th 1872		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 3 Days 2 Hours Min. 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work		11. BIRTHPLACE (State or foreign country) Montg. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William B Mobley				14. MOTHER'S MAIDEN NAME Louisa N. Griffrith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Medford Canby, Washington, D C,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Hypertension - Cardiac - 442X DUE TO Vanular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO 							INTERVAL BETWEEN ONSET AND DEATH 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 12 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1956 to Aug 6, 1956 , that I last saw the deceased alive on Aug 5, 1956 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher M.D.				ADDRESS (Street, city or town, state) Southwing, Md. P. O. 6-47			
DATE SIGNED Aug 7-56							
PHYSICIAN'S NAME (Type) Jack Schumacher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-56		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Glenwood, Howard Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.				24a. REC'D BY REGISTRAR DATE Aug 7-56			
				24b. REGISTRAR'S SIGNATURE Abraham G. Conde			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1964

LIBRARY

INSTRUCTIONS
1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8496

CERTIFICATE OF DEATH

Reg. Dist. No. 08444
218

1. PLACE OF DEATH CITY Montgomery COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Rd #1 Germantown		LENGTH OF STAY (In this place) 	
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD #1 GERMANTOWN		STREET ADDRESS (If rural give location) 	
3. NAME OF DECEASED (Type or Print) (First) Nannie (Middle) Jane (Last) Gates		4. DATE OF DEATH (Month) Aug (Day) 5 (Year) 1956	
5. SEX Female	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 23, 1873
9. AGE last birthday 83 yrs.		10. IF UNDER 1 YEAR Months 1 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home.	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Craft		14. MOTHER'S MAIDEN NAME Louisa Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Nettie G. Wright, Daughter.			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Carcinoma, vagina ANTECEDENT CAUSE(S) DUE TO menstruating venous thrombosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) hypertension, arteriosclerosis STATING UNDERLYING CAUSE LAST. DUE TO (C) 18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 		INTERVAL BETWEEN ONSET AND DEATH 30 years	
19a. DATE OF OPERATION 		19b. MAJOR FINDINGS OF OPERATION 	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 			
22. I hereby certify that I attended the deceased from May 16, 1956 , to Aug 5, 1956 , that I last saw the deceased alive on Aug 9, 1956 , and that death occurred at 12:45 P.M. from the causes and on the date stated above. SIGNATURE Jack H. Miller ADDRESS Frederick, Md. Aug. 5, 1956 M.D. Frederick, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 8, 1956	
NAME OF CEMETERY OR CREMATORY Ft. Lincoln, Cemetery		LOCATION (City, town, or county) (State) Prince Georges, Co. Md.	
24. REC'D BY REGISTRAR DATE 17 1956		25. FUNERAL DIRECTOR'S SIGNATURE Alfred E. Cook ADDRESS 1201, N. Market, St. FREDERICK, MARYLAND.	

BUREAU V. S.

AUG 7

1902

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8497

CERTIFICATE OF DEATH

18445

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>Box 29, Route</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Elizabeth Gotthardt</u>		4. DATE OF DEATH <u>Aug. 28</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1870</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Martha ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William Gotthardt - above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> DUE TO (b) <u>Strangulated Obstructed Hernia</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2-4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>Aug 28, 1956</u> that I last saw the deceased alive on <u>Aug 28, 1956</u> , and that death occurred at <u>9:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul D. Cantor</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4709 MONTGOMERY LANE</u>	
PHYSICIAN'S NAME (Type) <u>PAUL D. CANTOR</u>		<u>BETHESDA, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>8/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory Prince George County, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>8-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNTAU 4

EP 4 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68446

8448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN TB 20yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Henry Grogg		4. DATE OF DEATH Aug 13 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 5th 1875
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 9 Days 8 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Smith Co. Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Phillip Grogg		14. MOTHER'S MAIDEN NAME Bettie Jane Keesee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Wyndham Grogg.		Address Rockville. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Left Ventricular Strain DUE TO Myopericarditis - Cardiac - Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 12 years (b) Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. s. p. m. 		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from Aug. 12, 1956 to Aug. 13, 1956 , that I last saw the deceased alive on Aug. 12, 1956 , and that death occurred at 5:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Schumacher M.D.		ADDRESS (Street, city or town, state) Bethesda, Md. Aug 14, 56	
PHYSICIAN'S NAME (Type) Jack Schumacher		DATE SIGNED Aug 14, 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-15-56	22c. NAME OF CEMETERY OR CREMATORY Darnestown	22d. LOCATION (City, town, or county) (State) Darnestown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg. Md.	
24a. REC'D BY REGISTRAR 8/16/56		24b. REGISTRAR'S SIGNATURE Laurell Kragtorp	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 188447

CERTIFICATE OF DEATH

Reg. Dist. No. 223

8423

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>213 Spring Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eveline Cynthia Hamilton</u>				4. DATE OF DEATH Month Day Year <u>8 8 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-82</u>	
9. AGE (In years last birthday) <u>74 yrs</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Solomon Scott</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-365080</u>		17. INFORMANT <u>Chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10+ years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Friday</u> , 1956, to <u>Aug 8</u> , 1956, that I last saw the deceased alive on <u>Aug 8</u> , 1956, and that death occurred at <u>12:01 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock, M.D.</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>Aug 8-56</u>			
PHYSICIAN'S NAME (Type) <u>J. M. WHITLOCK - M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Park</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. ...</u> ADDRESS <u>21 Canal St NW DC</u>				24a. REC'D BY REGISTRAR DATE <u>8/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>Fulton ...</u>	

U. S. DEPT. OF AGRICULTURE

AUG 13 1955

U. S. DEPT. OF AGRICULTURE
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8498

CERTIFICATE OF DEATH

08448

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN b 26 days		d. STREET ADDRESS 1138 12th St., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carlous Middle Conrad Last HAWKINS		4. DATE OF DEATH Month August Day 2 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lucinda SNOWDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. 151-16-6769	
17. INFORMANT (wife) Mrs. Susie E. HAWKINS (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Ligustration DUE TO (c) Pneumonic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Immediate 2 y 10 Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 July , 1956 , to 2 August , 1956 , that I last saw the deceased alive on 2 August , 1956 , and that death occurred on 00:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gerald I. Shugoll M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-2-56	
PHYSICIAN'S NAME (Type) Gerald I. SHUGOLL, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-7-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. L. JARVIS		ADDRESS Washington, DC 1432 U. St., N.W.	
24a. REC'D BY REGISTRAR DATE 8-2-56		24b. REGISTRAR'S SIGNATURE Mary E. Carroll	

THE UNIVERSITY OF CHICAGO

AUG 3

1990

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08449 213

8449

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 908 Viers Mill Rd. - King's Nursing Home		e. STREET ADDRESS 213 Baltimore Road	
3. NAME OF DECEASED (Type or print) First Martin Middle F. Last HEIM		4. DATE OF DEATH Month August Day 18, Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 12	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bldg. Contractor-Ret.		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Heim		14. MOTHER'S MAIDEN NAME Malinda Kemp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Martin C. Heim-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Thrombosis DUE TO (c) gen. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr 75 hrs Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11/56 , 19 56 , to 8/20/56 , 19 56 , that I last saw the deceased alive on 8/18/56 , 19 56 , and that death occurred at 4:32 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen M. Jones M.D.		ADDRESS (Street, city or town, state) Rockville Md DATE SIGNED 8/20/56	
PHYSICIAN'S NAME (Type) Stephen M. Jones M.D.		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/21/56	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. - Bethesda		24a. REC'D BY REGISTRAR Aug 21 1956	24b. REGISTRAR'S SIGNATURE Lawell Knight

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon flippers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUG 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8499

CERTIFICATE OF DEATH

08450

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>Rt. #1, Bonifant Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Edward</u> Last <u>Henderson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/9/83</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired—Pound Master</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Albert Henderson</u>			
14. MOTHER'S MAIDEN NAME <u>Martha (unknown)</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT Address <u>Hospital Records & Wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u> Years _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>5/1/</u> , 19 <u>56</u> , to <u>8/22/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/22/</u> , 19 <u>56</u> , and that death occurred at <u>10:45AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u>				DATE SIGNED <u>8/22/56</u>			
ACTUAL SIGNATURE <u>J. W. Bird, M. D.</u>				PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Presbyterian Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Darnestown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey, Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur B. Lawrence</u>	

MEDICAL CERTIFICATION

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RECEIVED

AUG 29 1956

BUREAU V. S.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film

8590

CERTIFICATE OF DEATH

08451

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 1015 Noyes Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Lawton Middle G. Last Herriman			4. DATE OF DEATH Month August Day 18 Year 1956				
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/30/89		9 AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 18 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper - Gen. Services Adm.			10b. KIND OF BUSINESS OR INDUSTRY Services Adm.			11. BIRTHPLACE (State or foreign country) Delaware	
12 CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Melvin Herriman				14. MOTHER'S MAIDEN NAME Katie Walters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17 INFORMANT Mrs. Ethel C. Herriman-1015 Noyes Dr. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis, bilateral (Pneumonitis) DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3805 McKinley St. N.W., Wash. 15, D.C.	
20f. (City or town) Washington, D. C.				20g. (County) (State)			
21. I certify that I attended the deceased from August 11, 1956 , to August 18, 1956 , that I last saw the deceased alive on August 18, 1956 , and that death occurred at 9:18 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. A. Krause				DATE SIGNED August 18, 1956			
PHYSICIAN'S NAME (Type) Edward A. Krause, M.D.				ADDRESS (Street, city or town, state) 3805 McKinley St. N.W., Wash. 15, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/21/56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR 21-56		24b. REGISTRAR'S SIGNATURE Francis M. Hines	

BUREAU V. S.

JUG 1956

RECEIVED

8501

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORRIS</u>				c. LENGTH OF STAY IN It <u>2 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. PETER'S HOSPITAL</u>				d. STREET ADDRESS <u>4807-51st Place</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Bessie Freeman Hickey</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB/14/1888</u>	
9. AGE (In years, last birthday) <u>72</u>		IF UNDER 1 YEAR: Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		IF UNDER 24 HRS: Hours <u>10</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. BIRTHPLACE (State or foreign country) <u>CHARLES COUNTY, MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>ERNEST FREEMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. TULMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or date of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Wm R. Hickey</u>				Address <u>4807-51st Pl. EDMONSTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> + 100.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>8/6</u> , 19 <u>56</u> , to <u>8/7</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug 7</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles M. Weber</u>				M.D. <u>12600 Parkland Dr</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES M. WEBER</u>				ADDRESS (Street, city or town, state) <u>ROCKVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>COLMAR MARCHE PR GEO CO, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chamber Co</u>				ADDRESS <u>Greenleaf Ind.</u>			
24a. REC'D BY REGISTRAR <u>G.9</u>				24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U A FRANCE

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1915
1915
1915

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08453

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 8502 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN TB <u>2 1/2</u> hrs.		d. STREET ADDRESS <u>2214 Pratt St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hubert Bertra nd Hinkle</u>		4. DATE OF DEATH Month Day Year <u>8/19/56</u> <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/31</u>
9. AGE (in years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. _____	
IF UNDER 24 HRS. Hours Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool and die maker</u>	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jacob Hinkle</u>	
14. MOTHER'S MAIDEN NAME <u>Edna Kimberlin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Bertha Hinkle (wife) Same as Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage and laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bullet wound in left skull</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs. 10 M</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Self inflicted 22 rifle bullet wound in left skull</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:50 p.m.</u> <u>8/19/56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>	20f. (City or town) (County) (State) <u>Burtonsville Montg Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>8/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 23/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stone Hall</u>		22d. LOCATION (City, town, or county) (State) <u>Jordan Mines Va -</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arvill funeral home Coalington</u>		ADDRESS <u>Coalington Va</u>	
24a. REC'D BY REGISTRAR <u>DATE 8-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Katherine B. Lawler</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AUG 28 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8503

CERTIFICATE OF DEATH

Reg. Dist. No.

08454

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital; Bethesda, Md.		d. STREET ADDRESS 2325 Tracey Place	
3. NAME OF DECEASED (Type or print) First Carl Middle (none) Last HINSHAW		4. DATE OF DEATH Month August Day 5 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 July 1894
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Congressman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William HINSHAW		14. MOTHER'S MAIDEN NAME Anna Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Wilberta R. HINSHAW		Address (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: Myocarditis, toxic IMMEDIATE CAUSE (a) DUE TO pneumonia, interstitial (organism unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) generalized arteriosclerosis & involvement of aortic valve.		INTERVAL BETWEEN ONSET AND DEATH 9 days 11 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 July , 19 56 , to 5 August , 19 56 , that I last saw the deceased alive on 5 August , 19 56 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruce L. Canaga, Jr.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
DATE SIGNED 8-6-56			
PHYSICIAN'S NAME (Type) Bruce L. CANAGA, Jr. CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9 August '56	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons		ADDRESS Washington, DC 1756 Penn. Ave., N.W.	
24a. REC'D BY REGISTRAR DATE 8-6-56		24b. REGISTRAR'S SIGNATURE Mary E. Carroll	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU W. E.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08455
215

Reg. Dist. No.

8504

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		c. LENGTH OF STAY IN 1b 7 hrs 17 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. STREET ADDRESS Traylor #10	
3. NAME OF DECEASED (Type or print) First Anna Middle Darlene Last HITE		4. DATE OF DEATH Month August Day 24 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-56
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Alfred Dale HITE		14. MOTHER'S MAIDEN NAME Frances Mae HALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Father Alred D. HITE TM USN		Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 hours 17 min			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 24 Aug , 19 56 , to 24 Aug , 19 56 , that I last saw the deceased alive on 24 Aug , 19 56 , and that death occurred at 10:30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John H. Mazur M.D.		USNH NNMC Bethesda, Maryland	
PHYSICIAN'S NAME (Type) J. H. MAZUR LT MC EDR		USNH NNMC Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 30 Aug 56	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia	22d. LOCATION (City, town, or county) (State)
23. FOR THE DIRECTOR'S SIGNATURE R.A. Humphrey R.A. Humphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 25 Aug 56	24b. REGISTRAR'S SIGNATURE Mary E. Carrelly

MEDICAL CERTIFICATION

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ROBERT V. S.

1910

RECEIVED

CERTIFICATE OF DEATH

18456

Reg. Dist. No. 223

8424

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>2 hr - 43 min</u>		d. STREET ADDRESS <u>2609 Nicholson St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leahey Sanatorium Hospital</u>		e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hubbs</u> Middle <u>Hubbs</u> Last <u>Hubbs</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19, 1956</u>
9. AGE (In years last birthday) yrs <u>2</u> Months <u>4</u> Days <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Dorsey Hubbs</u>		14. MOTHER'S MAIDEN NAME <u>Berlin Louise Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>260917408</u>	
17. INFORMANT <u>Father - 2609 Nicholson St</u>		Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atedence</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Prematurity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/19, 1956</u> to <u>8/20, 1956</u> , that I last saw the deceased alive on <u>8/20, 1956</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Chinn, M.D.</u>		DATE SIGNED <u>8/20/56</u>	
PHYSICIAN'S NAME (Type) <u>925 Pershing Drive, Silver Spring, Md.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>8-21-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hosp.</u>	22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. HARE</u>		24a. REC'D BY REGISTRAR <u>8/23/56</u>	
ADDRESS <u>1600 Park Ave</u>		24b. REGISTRAR'S SIGNATURE <u>John B. K. O'Neil</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1056

1056

1056

8505

CERTIFICATE OF DEATH

18457
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. STREET ADDRESS 1745 Lanier Place, N. W.				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle Adele Last Holzmann				4. DATE OF DEATH Month August Day 26 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1887	
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker				10b. KIND OF BUSINESS OR INDUSTRY Garment		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Moses Neuberger				14. MOTHER'S MAIDEN NAME Meta Rosenfeld			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579, 16 9674		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the breast DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 wks. 29 months.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 30, 19 56 to August 26, 19 56 , that I last saw the deceased alive on August 26, 19 56 , and that death occurred at 1:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clyde O. Brindley M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) Clyde O. Brindley, M. D.				DATE SIGNED 8/27/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/28/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	
22d. LOCATION (City, town, or county) (State) Hyattsville, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE 3. Dargatzis & Sons				ADDRESS 3501 14th St., N. W.		24a. REC'D BY REGISTRAR 8-30-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8596

CERTIFICATE OF DEATH

Reg. Dist. No.

08458

217

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Zion		c. LENGTH OF STAY IN 1b 2 Year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Russell Rest Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville Maryland	
		d. STREET ADDRESS Laytonsville Maryland	
3. NAME OF DECEASED (Type or print) CARRIE HOPKINS		4. DATE OF DEATH Month Aug. Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1879 77
9. AGE (In years lost birthday) yrs. 77		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dick Copeland		14. MOTHER'S MAIDEN NAME Elizabeth Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ###		16. SOCIAL SECURITY NO. #####	
17. INFORMANT Mrs Maggie Dwyer		Address Laytonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right Hemiplegia (c) Right Hemiplegia			INTERVAL BETWEEN ONSET AND DEATH 2 wks 4 wks 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SP 11 19 55 to 7/31 19 56 that I lost saw the deceased alive on 8/1/56 12 56 , and that death occurred at SP 11 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird		ADDRESS (Street, city or town, state) DATE SIGNED Sandy Spring Maryland 8/1/56	
PHYSICIAN'S NAME (Type) DR J. W. Bird		Sandy Spring Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 6 1956	22c. NAME OF CEMETERY OR CREMATORY Brooke Grove	22d. LOCATION (City, town, or county) (State) Laytonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR 8-11-56		24b. REGISTRAR'S SIGNATURE Esther B. Lawler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

AUG 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08459

8507

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Accomack	
c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 106 Smith Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		First Lee		Middle Hudson	
4. DATE OF DEATH Month August		Day 7		Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1901		9. AGE (In years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Joshua Hudson		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Cordilia J. Taylor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 227-05-7862		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mitral insufficiency X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) heart failure DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 18, 1956 , to August 7, 1956 , that I last saw the deceased alive on August 7, 1956 , and that death occurred at 2:22 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Richard J. Sanders		ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Md.		DATE SIGNED 8/7/56	
PHYSICIAN'S NAME (Type) Richard J. Sanders, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 10, 1956		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery	
22d. LOCATION (City, town, or county) Chincoteague Isl. Va.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS 7557 misc. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 8/10/56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson					

1956

1956

1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8425

CERTIFICATE OF DEATH

68460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>Trinidad</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takama Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port-of-Spain</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>2 A Queen</u>	
3. NAME OF DECEASED (Type or print) <u>Mohamed N NIN Ibrahim</u>		4. DATE OF DEATH <u>Aug 21 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-90</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Minister + President</u>	
11. BIRTHPLACE (State or foreign country) <u>Trinidad</u>		12. CITIZEN OF WHAT COUNTRY? <u>Britishian</u>	
13. FATHER'S NAME <u>Khadatho Ibrahim</u>		14. MOTHER'S MAIDEN NAME <u>Ameeran (no last name)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Sen + Am. Ibrahim</u>	
17. INFORMANT <u>Sen + Am. Ibrahim</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholecystectomy</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-13-</u> 19 <u>56</u> , to <u>8-21-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-21-56</u> , 19 <u>56</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur E. Coyne</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Cabon Park</u>	
PHYSICIAN'S NAME (Type) <u>Arthur E. Coyne MD.</u>		DATE SIGNED <u>md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 23-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PORT OF SPAIN</u>		22d. LOCATION (City, town, or county) (State) <u>TRINIDAD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawrence, Sons</u> ADDRESS <u>1756 P. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>J. W. Wilson</u> DATE <u>8-22-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dodd</u>	

BUCKET A 2

1006

1006

8508

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck,			c. LENGTH OF STAY IN lb life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS Norbeck,		
3. NAME OF DECEASED (Type or print) First William Middle Henson Last Johnson			4. DATE OF DEATH Month August Day 17 Year 56		
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1893	9. AGE (In years last birthday) yrs 63	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Henry Johnson			14. MOTHER'S MAIDEN NAME Emma Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT George E. Johnson			Address Gaithersburg, Md. Route 1		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Nephritis Anuria Coma DUE TO Diabetes Mellitus and Hypertensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiorenal Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 14, 1956 to August 17, 1956 , that I last saw the deceased alive on Aug. 17, 1956 , and that death occurred at 9:15 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Webster Sewell			ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring, Md.		
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			DATE SIGNED 8-17-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/21/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant,		22d. LOCATION (City, town, or county) (State) Norbeck, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden			ADDRESS Rockville, Md.		
24a. REC'D BY REGISTRAR DATE 8-22-56		24b. REGISTRAR'S SIGNATURE Estimude B. Lawley			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

9961 . 5th

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18462

8509

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>DC.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY CATHERINE KANE</u>				4. DATE OF DEATH Month Day Year <u>AUG. 17 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/5/10</u>	
9. AGE (In years last birthday) <u>45</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. <u>10 12</u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FED. HOME LOAN</u>			
11. BIRTHPLACE (State or foreign country) <u>Chevy Chase, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JOHN D. McAULIFFE</u>				14. MOTHER'S MAIDEN NAME <u>MARY O'CONNOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNK</u>			
17. INFORMANT <u>MC. JAMES S. McAULIFFE - BROTHER</u>				Address <u>4520 NICHOLS ST, CHEVY CHASE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Hemiplegia due to cerebral hemorrhage 1953</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> to <u>AUG. 17, 1956</u> , that I last saw the deceased alive on <u>AUG. 17, 1956</u> , and that death occurred at <u>5:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo M. Curtis</u> M.D.				ADDRESS (Street, city or town, state) <u>8218 WISCONSIN AVE</u> DATE SIGNED <u>8/17/56</u>			
PHYSICIAN'S NAME (Type) <u>LEO M. CURTIS M.D.</u>				<u>BETHESDA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda,</u>				ADDRESS Maryland		24a. REC'D BY REGISTRAR <u>DATE 8-20-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

BUREAU V. S.

AUG 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8450

CERTIFICATE OF DEATH

08463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 North Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Alfred Last King				4. DATE OF DEATH Month Aug. Day 23 Year 19 56			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1887		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Simon King				12. CITIZEN OF WHAT COUNTRY? U.S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212 18 8629		17. INFORMANT Mrs Fannie King Address 118 North Lane., Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Several hours years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 31 p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to 8/23 , 19 56 , that I last saw the deceased alive on 16 Aug , 19 56 , and that death occurred at 5:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE R. C. Macanjin MD from M.D. S. N. Jones MD							
PHYSICIAN'S NAME (Type) R. C. Macanjin MD 809 Veismuller Rd. Rockville, Md.							
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF 8/27/56		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park		23d. LOCATION (City, town, or county) (State) Rockville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden Address Rockville Md				24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE Laurel Kraglove	

BUREAU V. S.

AUG 29 1956

RECEIVED

8510 CERTIFICATE OF DEATH

Reg. Dist. No. 215

08464

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>5 hr. 2 min.</u>		d. STREET ADDRESS <u>1303 Saratoga Ave., N.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Theodore</u> Last <u>KLARIDES</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-56</u>
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John KLARIDES</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alma ROYSTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) John KLARIDES (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATURITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) <u>31 WKS. GEST</u> INTERVAL BETWEEN ONSET AND DEATH: <u>5 hr. 2 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3 August</u> , 19 <u>56</u> , to <u>3 August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 August</u> , 19 <u>56</u> , and that death occurred at <u>11:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Daniel Shuptar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 8-6-56</u> PHYSICIAN'S NAME (Type) <u>Daniel Shuptar, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7 Aug. 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>8-6-56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary E. Carroll</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1900

RECEIVED

68465/4

8511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pa. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Silver Spring		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Rudolph Kluckhuhn		4. DATE OF DEATH Month 8 Day 7 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15, 1872
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY general contractor	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Rudolph Kluckhuhn		14. MOTHER'S MAIDEN NAME Caroline Elizabeth Phyle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Fred G. Kluckhuhn, Laurel, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Attack DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Contributory: Cardio-Vascular Sclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH One hour.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 - 16 - 19 55 to 8 - 7 - 19 56 , that I last saw the deceased alive on 8 - 7 - 19 56 , and that death occurred at 11:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. J. Kistler M.D.		ADDRESS (Street, city or town, state) Cedarcroft San. & Hospital. DATE SIGNED 8/8/56	
PHYSICIAN'S NAME (Type) A. J. Kistler, M. D.		Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug 10, 1956	Lawson Memorial Park	Montgomery, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Roudsberry Laurel, Md.		24a. REC'D BY REGISTRAR DATE 8/20/56	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles Carter	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

AUG 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8426

CERTIFICATE OF DEATH

08466 223
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>1428 University Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>-</u> Last <u>Krieger</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/88</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Schroeder</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Vordenbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mr. Henry Krieger - Son - same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOCLERIC HEART DIS - CHRONIC CONC</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u> <u>4 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>55</u> , to <u>AUG 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>AUG 5</u> , 19 <u>56</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>1352 University Lane, Hyattsville</u> <u>AUG 5, 1956</u>							
ACTUAL SIGNATURE <u>Harold Sterling</u> M.D.				PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW YORK</u>		22d. LOCATION (City, town, or county) (State) <u>N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur D'Alora 254 PARKER ST. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>8/7/56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur D'Alora</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 10 1956

U.S. DEPT. OF JUSTICE

CERTIFICATE OF DEATH

Reg. Dist. No.

216

8512

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>md.</i> c. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>4904 Cumberland Ave</i>	
3 NAME OF DECEASED (Type or print) First <i>Baby</i> Middle <i>Boy</i> Last <i>Kuyatky</i>		4 DATE OF DEATH Month <i>Aug</i> Day <i>16</i> Year <i>1956</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Aug 16/52</i>
9 AGE (In years last birthday) yrs. <i>2</i> Months <i>30</i> Days <i>30</i> Hours <i>30</i> Min <i>30</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11 BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Alexander Kuyatky</i>	
14. MOTHER'S MAIDEN NAME <i>Katharine Kuchnareff</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>112</i>		17. INFORMANT <i>Father</i> Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> DUE TO (b) <i>Atelectasis</i> DUE TO (c) <i>Prematurity</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <i>19</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 16</i> , 19 <i>56</i> , to <i>Aug 16</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Aug 16</i> , 19 <i>56</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles R. Hughes</i> M.D.		ADDRESS (Street, city or town, state) <i>8226 Foxton St</i> DATE SIGNED <i>17 Aug 56</i>	
PHYSICIAN'S NAME (Type) <i>Charles R. Hughes</i>		<i>Silver Spring, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-21-1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda Md</i>	24a REC'D BY REGISTRAR <i>20-56</i> 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

08468

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3515 Runnymede Place, N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Matilda Last Lee		4. DATE OF DEATH Month August Day 19 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1889
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Barker		14. MOTHER'S MAIDEN NAME Sarah Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 115 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystadenocarcinoma of Ovary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephronphrosis, rt. kidney.			INTERVAL BETWEEN ONSET AND DEATH 14 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 4, 1956 , to August 19, 1956 , that I last saw the deceased alive on August 19, 1956 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clyde O. Brindley M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Clyde O. Brindley, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8/22/56	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.- Washington, D. C.		24a. REC'D BY REGISTRAR 8-22-56 DATE	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. E.

AUG 10 1900

RECEIVED
AUG 10 1900

8514

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 41 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nettie Eugenia Leizear				4. DATE OF DEATH Month August Day 23 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/94	
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min. 0		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Thomas Jefferson Grooms				14. MOTHER'S MAIDEN NAME Caroline Rebecca Howes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Address Hospital Record (Husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho-sarcoma of DUE TO Pancreas with metastases Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/1 , 19 56 , to 8/23/56 , 19 56 , that I last saw the deceased alive on 3/24/56 , 19 56 , and that death occurred at 5:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Sp DATE SIGNED 8/24/56							
22. I certify that I attended the deceased from 2/1 , 19 56 , to 8/23/56 , 19 56 , that I last saw the deceased alive on 3/24/56 , 19 56 , and that death occurred at 5:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Sp DATE SIGNED 8/24/56							
23. FUNERAL DIRECTOR'S SIGNATURE ROY W BARBER LATONSVILLE MD							
24a. REC'D BY REGISTRAR DATE 8-27-56							
24b. REGISTRAR'S SIGNATURE Evelyn B Lawler							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 29 1956

RECEIVED

8515

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14326 Colesville Rd.		d. STREET ADDRESS 14326 Colesville Rd.	
3. NAME OF DECEASED (Type or print) First Joseph Middle P. Last LENNON		4. DATE OF DEATH Month Aug. Day 20 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 16-1889
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Retired		10b. KIND OF BUSINESS OR INDUSTRY N. S. Govt	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lennon		14. MOTHER'S MAIDEN NAME Anne Gorman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Reserve		16. SOCIAL SECURITY NO None	
17. INFORMANT Eileen Somerville		Address 9818 Montauk Bethesda Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial failure DUE TO coronary sclerosis with occlusion and post-myocardial infarction and heart failure 18 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 to 3 m.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 1954 , to Aug. 20, 1956 , that I last saw the deceased alive on Aug. 14, 1956 , and that death occurred at 6:45 A. M. from the causes and on the date stated above			
ACTUAL SIGNATURE R. Stephen Hulbert		ADDRESS (Street, city or town, state) 3000 Dent Place, NW	
PHYSICIAN'S NAME (Type) R. Stephen Hulbert, M.D.		DATE SIGNED Aug. 20, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 1400 Chasing St. Wash. D. C. N. W.	
24a. REC'D BY REGISTRAR 7/22/56		24b. REGISTRAR'S SIGNATURE Frances [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CREAN V. S.

AUG 24 19

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

18471

8516

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery Co.</u>		STATE <u>MARYLAND</u>		STATE <u>Washington, D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colesville</u>		LENGTH OF STAY (In this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marilea Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3218- 4th. Street S.E.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES P. LISTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 17th. 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 25 -1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steam Fitter</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Liston</u>				14. MOTHER'S MAIDEN NAME <u>Helen Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ellinor N. Liston 3218- 4th. St. S. E. Washington, D.C.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>B. bronchial pneumonia</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>acute congestive heart failure</u>						<u>1 1/2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Arteriosclerosis</u>						<u>2 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-12, 1955</u> , to <u>8-17, 1956</u> , that I last saw the deceased alive on <u>8-16, 1956</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John P. Rogers</u> M.D.				ADDRESS (Street, city, town, state) <u>1919 5th St. S.E. Washington, D.C.</u>		DATE SIGNED <u>8-17-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 20-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR DATE <u>AUG 21 1956</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sirreana Patton</u>		ADDRESS <u>1661- Good Road SE Washington, DC.</u>	

RECEIVED

AUG 20 1956

BUREAU V. S.

8427

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>13 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Sanitarium & Hos</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Austin</u> Middle <u>VERNON</u> Last <u>MAIN</u>		4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-04</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>Philip Kiefer Main</u>		14. MOTHER'S MAIDEN NAME <u>Aldo Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>579-07-7125</u>	
17. INFORMANT <u>Mrs. ESTELLA A. MAIN</u>		Address <u>Takoma Park, Md. 6606 COCKERILLE AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Glomerular Nephritis</u> DUE TO (c) <u>anuria</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 23, 1956</u> to <u>Aug 8, 1956</u> , that I last saw the deceased alive on <u>Aug 7, 1956</u> , and that death occurred at <u>130 P M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>AUG 8, 1956</u>	
ACTUAL SIGNATURE <u>M. F. Fottman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>M. F. FOTTMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 11, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON EM. REPOSE PRINCE GEORGE CO Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>157 Carroll St. N.W. Washington 14, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>8/10/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

JUN 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8517

CERTIFICATE OF DEATH

Reg. Dist. No. 216

118473

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville RFD #3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>			d. STREET ADDRESS <u>15605 Colesville Rd.</u>		
3. NAME OF DECEASED (Type or print) <u>Evelyn</u> First Middle Last			4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-21</u>		9. AGE (In years last birthday) <u>35</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>	
13. FATHER'S NAME <u>Joseph Chmura</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service) <u>####</u>			16. SOCIAL SECURITY NO <u>Unknown</u>		
17. INFORMANT <u>Dan J. Marlowe - husband</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute hemorrhagic Pancreatitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>0810</u>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July 31, 1956</u> to <u>August 4, 1956</u> , that I last saw the deceased alive on <u>August 3, 1956</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Bennet A. Porter Jr., M.D.</u>			ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>		
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter Jr.</u>			DATE SIGNED <u>Aug. 4, 1956</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 7 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Michaels (Cath)</u>	
22d. LOCATION (City, town, or county) <u>Bridgeport, Connecticut</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>			24a. REC'D BY REGISTRAR <u>7-56</u>		
ADDRESS <u>Laytonville, Md.</u>			24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8518

CERTIFICATE OF DEATH

08474

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EILEEN MARIE MARRA</u>				4. DATE OF DEATH Month Day Year <u>8 - 20 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-15</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bronx New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>FRANK KAVANAGH</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Tierney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Raymond N. Marra- Item # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Cerebral Hemorrhage, Rt</u> DUE TO <u>Rupt. Branch Ant. Communicating Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Anomalous (?)</u> DUE TO (c) <u>Congenital Anomalous (?)</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1</u> , 19 <u>56</u> , to <u>8-20</u> 19 <u>56</u> that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>56</u> , and that death occurred at <u>10:25</u> PM, from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-Transit</u>		<u>8.21.56</u>		<u>Calvary</u>		<u>Queens, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

UNITED STATES

1956

UNITED STATES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **18475/4**

8519

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 9 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,121 MARKHAM DRIVE				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
f. STREET ADDRESS 10,121 MARKHAM DRIVE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle DANIEL Last MARTIN				4. DATE OF DEATH Month AUGUST Day 23 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/29/93	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Chief, State Dept. U.S. Gov't.				10b. KIND OF BUSINESS OR INDUSTRY Northampton, Mass.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Martin				14. MOTHER'S MAIDEN NAME Ellen Hession			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Catherine G. Martin, 10,121 Markham Drive Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/27/56		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Humphrey				24a. REC'D BY REGISTRAR 8/29/56		24b. REGISTRAR'S SIGNATURE Francis Potter	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1956

BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808476

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 212

8520

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> c. LENGTH OF STAY IN 1b <u>3 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>rural</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> d. STREET ADDRESS <u>rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Mathias</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>1956</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/4/1872</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>				11. BIRTHPLACE (State or foreign country) <u>Mathias, West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Mathias</u>						14. MOTHER'S MAIDEN NAME <u>Barbara Fulks</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Georgiana Mathias (wife)</u> Same as Item 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>8/6/56</u>					
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug. 7 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill</u>				22d. LOCATION (City, town, or county) <u>Redland</u> (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>						ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/8/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. Give Page 5 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11/11/56

3 12 1956

11/11/56

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 08477

8521 **CERTIFICATE OF DEATH**

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9310 2nd AVENUE				STREET ADDRESS (If rural give location) 9310 2nd AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY		(Middle) ELLEN		(Last) McINTOSH		(Month) (Day) (Year) AUG. 10 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 11/19/10	9. AGE last birthday 45 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MINNESOTA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK B. MOOERS				14. MOTHER'S MAIDEN NAME VELMA F. Du BOIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 220-09-5827		17. INFORMANT & ADDRESS Mr. Albert McIntosh, 9310 2nd Ave. Silver Spring, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 2 hours			
ANTECEDENT CAUSE(S) DUE TO (B) Meningioma				5 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. DATE OF OPERATION April, 1954				19b. MAJOR FINDINGS OF OPERATION Meningioma - base of anterior fossa			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 54, to August 1956, that I last saw the deceased alive on Aug. 10th, 1956, and that death occurred at 4:45 p.m. from the causes and on the date stated above.							
SIGNATURE Raymond Bradshaw, M.D.				ADDRESS (Street, city, town, state) 10331 Old Bladensburg Road, Silver Spring, MD.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				DATE THEREOF 8/13/56		NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Walter P. Pumphrey	
DATE 8-1-56				ADDRESS SILVER SPRING, MD.			

BUREAU V. 1

AUG 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8522

CERTIFICATE OF DEATH

18478
276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 115 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health				d. STREET ADDRESS - -			
3. NAME OF DECEASED (Type or print) First Hilda Middle Mae Last McRae				4. DATE OF DEATH Month August Day 3 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1900	
9. AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months 3 Days 3 Hours 19 Min.		IF UNDER 24 HRS Months 3 Days 3 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Nova Scotia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George MacGuire				14. MOTHER'S MAIDEN NAME Laura Logan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record Address Bethesda 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive metastatic carcinoma 1701X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) primary site uterine cervix DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from April 10, 1956 to August 3, 1956 , that I last saw the deceased alive on August 3, 1956 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE James R. Stetson M.D. M.D. The Clinical Center NATIONAL INSTITUTES OF HEALTH Bethesda, Maryland							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Transportation		8/5/56		Cynon		Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE F. Busche Sons & Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE 7 1956		24b. REGISTRAR'S SIGNATURE Russell Thompson	

ROBERT V. B.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8523

CERTIFICATE OF DEATH

08479

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Hollywood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 12217 Iredell Avenue	
3. NAME OF DECEASED (Type or print) First Anthony Middle Washington Last Medlock		4. DATE OF DEATH Month August Day 14 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 11, 1933
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 22 Days 14 Hours 19 Min 56	11. IF UNDER 24 HRS Hours 19 Min 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Chauffeur	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Travis Medlock		14. MOTHER'S MAIDEN NAME Mary Alice Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 462-44-1942	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 133X Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) disseminated coccidia mycosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 10, 1956 to August 14, 1956 , that I last saw the deceased alive on August 14, 1956 , and that death occurred at 9:34 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Dolan Jr. M.D.		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) Thomas F. Dolan, Jr., M. D.		DATE SIGNED 8/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/15/56		22c. NAME OF CEMETERY OR CREMATORY 11 ASH	
22d. LOCATION (City, town, or county) D.C.		22e. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE FRAZIER'S FUNERAL HOME 389 Q		24a. REC'D BY REGISTRAR DATE 8/15/56	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 14 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

AUG 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8428

CERTIFICATE OF DEATH

18480
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>10301 Douglas Ave</u> b. COUNTY <u>Maryland-Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>10301 Douglas Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Walter Bellum</u> First <u>Bellum</u> Middle <u>Miller</u> Last <u>Miller</u>				4. DATE OF DEATH <u>Aug. 13</u> 19 <u>56</u> Month <u>Aug.</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-99</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>		IF UNDER 24 HRS: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Radio engineer</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Bellum Miller Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Maria Humphries</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Son - Mr. Richard Miller</u>				Address <u>6143 S. S. Rd. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO <u>Pyemia</u> DUE TO <u>Pulmonary fibrosis</u> DUE TO <u>820X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>8 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 7</u> , 19 <u>56</u> , to <u>Aug 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 13</u> , 19 <u>56</u> , and that death occurred at <u>8:23</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 B. Orleans</u> DATE SIGNED <u>8/13/56</u> ACTUAL SIGNATURE <u>H B. ORLEANS</u> M.D. <u>H B. ORLEANS</u> PHYSICIAN'S NAME (Type) <u>H B. ORLEANS</u>							
22a. BURIAL, CREMATION, REBURY (Specify) <u>burial</u>				22b. DATE THEREOF <u>8/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co</u> ADDRESS <u>2901 14th St NW</u>				24a. REC'D BY REGISTRAR <u>8-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>William R. Ridd</u>	

JUG 16 1956

BUREAU V. B.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15-ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8451

Reg. Dist. No.

184813

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 1 month 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1661 Crescent Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Waverly Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle H. Last MINOR				4. DATE OF DEATH Month August Day 4 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1878		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 10 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Representative		10b. KIND OF BUSINESS OR INDUSTRY Retired- Landis Tool Co.		11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John H. Minor				14. MOTHER'S MAIDEN NAME Sue Laurence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT C. 1 Andree #. Minor-Wife		Address See Item #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 8-7-56		22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Franklin County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Laurel Krayton			

DATE STAMPED
Aug. 4 1956
8-4-56

13 A. 11

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8524

CERTIFICATE OF DEATH

Reg. Dist. No. 18482

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 41 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 200 "C" Street, S. E.			
3. NAME OF DECEASED (Type or print) First Hal Middle (MIL) Last Mitchell				4. DATE OF DEATH Month August Day 7 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. B. DATE OF BIRTH October 27, 1892	
9. AGE (In years last birthday) 63 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. to Sgt.-at-Arms		10b. KIND OF BUSINESS OR INDUSTRY U. S. Senate		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Robert Willis Mitchell		14. MOTHER'S MAIDEN NAME Margaret P. Wellman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 527-07-2802		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) intermediate cardiac vascular disease						INTERVAL BETWEEN ONSET AND DEATH 90 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 27 , 1956, to August 7 , 1956, that I last saw the deceased alive on August 7 , 1956, and that death occurred at 12:02A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Tuohy M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) John H. Tuohy, M. D.				DATE SIGNED 8/7/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 8/10/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION (City, town, or county) (State) Suitland Maryland				22e. REC'D BY REGISTRAR 8-9-56			
22f. FUNERAL DIRECTOR'S SIGNATURE Joseph Hewlerison, Wash, D.C.				22g. REGISTRAR'S SIGNATURE Beenie M. Thompson			

BUREAU V. 2

AUG 18 1950

1100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8525

CERTIFICATE OF DEATH

Reg. Dist. No.

18483

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u></p>		<p>c. LENGTH OF STAY IN 1b <u>10 days 4 1/2 hrs.</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u></p>				<p>d. STREET ADDRESS</p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>P</u> Last <u>MOORE</u></p>				<p>4. DATE OF DEATH Month <u>8</u> - Day <u>24</u> Year <u>1956</u></p>			
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>Colored</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>12-25-88</u></p>	
<p>9. AGE (In years last birthday) <u>67</u> yrs.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mount Foreman</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>							
<p>13. FATHER'S NAME <u>HENRY MOORE</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>MARGARET JACKSON</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>Hannah Turner - daughter</u> <u>Germanstown, Md.</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis & Ulcers</u> DUE TO (b) <u>Colocele, Small Intestine (Revised 8-15-56)</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p>						<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>						<p>19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <u>8-14</u>, 19<u>56</u>, to <u>8-24</u>, 19<u>56</u>, that I last saw the deceased alive on <u>8-24</u>, 19<u>56</u>, and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED</p>							
<p>ACTUAL SIGNATURE <u>Philip Burka</u></p>				<p>M.D. <u>1834 - Conn. Ave. - N.W.</u> <u>Wash. D.C.</u></p>			
<p>PHYSICIAN'S NAME (Type) <u>Philip Burka</u></p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify)</p>		<p>22b. DATE THEREOF <u>8/27/56</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Gloppert, Md.</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden - Rockville, Md.</u></p>				<p>24a. REC'D BY REGISTRAR <u>28-29-56</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for burial as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 31 1907

RECEIVED

8526

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>4521 Rosedale Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>KEITH</u> Middle <u>ALAN</u> Last <u>MOTTER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1956</u>	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR: Months <u>1</u> Days <u>16</u> Hours <u>16</u> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DANIEL LESTER MOTTER</u>				14. MOTHER'S MAIDEN NAME <u>MARJORIE T. LEMPLE BEAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MOTHER.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline Membrane Disease</u> DUE TO <u>161.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Intrauterine respiratory effort</u> DUE TO <u>Breach presentation</u> (c) <u>Prematurity</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 30, 1956</u> to <u>August 1, 1956</u> , that I last saw the deceased alive on <u>July 31, 1956</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Vita R. Jaffe</u>				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave Bethesda, Md.</u>			
DATE SIGNED <u>Aug 14, 1956</u>							
PHYSICIAN'S NAME (Type) <u>VITA R. Jaffe M.D.</u>				DATE <u>8-14-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>8/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey - Bethesda, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>Beau M. Thompson</u>	
DATE <u>8-2-56</u>				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

74513 XV2

ROBERT W. F.

JUG 5 1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08485

CERTIFICATE OF DEATH

Reg. Dist. No.

223

8429

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>119 Indian Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Also known as: Rudolph A. Siligmueller</u> <u>Rudolph Siligmueller</u>		4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant, U. S. Govt.</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Mueller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Heim</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>(1) Arteriosclerotic Heart Disease</u> DUE TO <u>(2) Coronary Thrombosis (old)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>(3) Cerebral Thrombosis (old)</u> <u>(4) Chronic Nephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(5) Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Undetermined</u> <u>6 months</u> <u>6 months</u> <u>Undetermined</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 12, 1956</u> to <u>Aug 18, 1956</u> , that I last saw the deceased alive on <u>Aug 17, 1956</u> , and that death occurred at <u>6:32 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warner L. Pumphrey</u> M.D.		ADDRESS (Street, city or town, state) <u>7835 Eastern Ave</u> DATE SIGNED <u>Aug 15, 1956</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>8/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner L. Pumphrey</u> ADDRESS <u>Silver Spring, Md.</u>		24. REC'D BY REGISTRAR <u>AUG 20 1956</u>	25. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

AUG 22 1900

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

8527

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS GREAT FALLS RD, RT. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CAROLINE LOUISE MULHERON		4. DATE OF DEATH Month Day Year 8 / 21 / 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/62
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME PATRICK HICKEY		14. MOTHER'S MAIDEN NAME MARY DELACY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. FRANCES M. SADD - DAUGHTER GREAT FALLS RD, RT. 2, ROCKVILLE, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema & Vasculature DUE TO Cholera Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Cardiac vascular accident DUE TO Hypertension (c) 7		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bethesda		20f. (City or town) (County) (State) md	
21. I certify that I attended the deceased from Aug 15, 1956 , to Aug 21, 1956 , that I last saw the deceased alive on Aug 21, 1956 , and that death occurred at 9:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, md DATE SIGNED 8-21-56			
ACTUAL SIGNATURE A. J. Brennan		PHYSICIAN'S NAME (Type) A. J. BRENNAN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 8-24-56	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's		22d. LOCATION (City, town, or county) (State) Johnson City, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR 8-23-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 11 1951

10/11/51

8529

CERTIFICATE OF DEATH

Reg. Dist. No.

118488

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>1311 Columbia Road, NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Murphy</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1895</u>
9. AGE (In years, last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Hessel, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Morris Murphy</u>		14. MOTHER'S MAIDEN NAME <u>MARY Mortenson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>369-12-2388</u>	
17. INFORMANT <u>Wife - Lucille Murphy</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Thrombosis, left descending coronary</u> DUE TO (c) <u>Atherosclerosis coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Few hours</u> <u>Few hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old abscess left kidney</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 Aug., 1956</u> , to <u>16 Aug., 1956</u> , that I last saw the deceased alive on <u>16 Aug., 1956</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Suburban Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. E. Ash</u>		DATE SIGNED <u>16 Aug. '56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/20/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>		ADDRESS <u>2901 14th St. Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 22 1956

RECEIVED

8528

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution; Residence before admission] a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>20A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bernard Seigler Farm</u>				d. STREET ADDRESS <u>5632 MacArthur Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Carthbert Murphy</u>				4. DATE OF DEATH Month Day Year <u>Aug 31 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-15</u>		9. AGE (in years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst - Buffalo Seal & Gavel Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miss</u>		11. BIRTHPLACE (State or foreign country) <u>Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>377-50-9593</u>		16. SOCIAL SECURITY NO. <u>377-50-9593</u>		17. INFORMANT <u>Mary Murphy</u> Address <u>5632 MacArthur Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Carbon monoxide poisoning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon monoxide poisoning</u> DUE TO <u>Found dead in auto</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>rose attached from exhaust to car</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Washington D.C.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/4/56</u>		<u>Rock Creek</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rev. Frank H. H.</u>				24a. REC'D BY REGISTRAR <u>4812 9th Ave. NW</u>		24b. STRAIGHT OR NATURE <u>Chas. E. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 7 19

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8530

CERTIFICATE OF DEATH

68489

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				d STREET ADDRESS 5507 13th St., N.W.			
3. NAME OF DECEASED (Type or print) First Jessie Middle I Last Noetzel				4. DATE OF DEATH Month 8 - Day 17 - Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1869	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tom Pope				14. MOTHER'S MAIDEN NAME Elizabeth Pugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records at Sanitarium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Broncho Pneumonia 1452.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Senile Dementia						INTERVAL BETWEEN ONSET AND DEATH 2 days 15 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-15-56 to 8-18- , 19 56 that I last saw the deceased alive on 8-15-56 , 19 56 , and that death occurred at 4:54 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5412 Colo Ave N.W. DATE SIGNED ACTUAL SIGNATURE A. J. Betz M.D. PHYSICIAN'S NAME (Type) Andrew J Betz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR 8-20-56 24b. REGISTRAR'S SIGNATURE Jessie M. Thompson	

BUREAU V. S.

AUG 22 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN 1b 6 weeks		d. STREET ADDRESS 113 South Adams Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) Waverley Sanitarium		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Hulings OFFUTT		4. DATE OF DEATH Month August Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1862
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 8 Days 27 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Hulings		14. MOTHER'S MAIDEN NAME Mary Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Ellen P. Ireland-dau. -Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY + THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH TWO HOURS TEN YEARS FIFTY YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 10, 1956 to Aug 3, 1956 , that I last saw the deceased alive on Aug 3, 1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.		ADDRESS (Street, city or town, state) 310 W. MONTGOMERY AVE. ROCKVILLE, MD.	
DATE SIGNED Aug 3, 1956			
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger, M.D.		310 W. Montgomery Ave. Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6/1956	
22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville, Montg. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS	
24a. REC'D BY REGISTRAR 8/6/56		24b. REGISTRAR'S SIGNATURE Laurel Kragtorp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 1906

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Inter 2 FilmG202 9-J-56 et

8531

CERTIFICATE OF DEATH

Reg. Dist. No. 218 08491

1. PLACE OF DEATH <i>Asbury Home, Gaithersburg</i> a. COUNTY <i>MONTGOMERY</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i> c. LENGTH OF STAY IN 1b <i>5 YEARS</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Asbury Methodist Home</i>				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i> d. STREET ADDRESS <i>1830 17th St., N.W.</i> <i>Asbury Methodist Home</i>			
3. NAME OF DECEASED (Type or print) First <i>VINA</i> Middle <i>ELLIOTT</i> Last <i>OPDYCKE</i>				4. DATE OF DEATH Month <i>8</i> Day <i>24</i> Year <i>1956</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-20-1872</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School TEACHER</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>OSCAR FITZALLEN ELLIOTT</i>				14. MOTHER'S MAIDEN NAME <i>HARRIET RATHBUN</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>577-30-5669</i>		17. INFORMANT <i>Asbury Methodist Home Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute heart failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>hypertension heart disease</i> DUE TO (c) <i>arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-11</i> , 1956, to <i>8-24</i> , 1956, that I last saw the deceased alive on <i>8-22</i> , 1956, and that death occurred at <i>8 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Sarah E. Glover</i>				M.D. <i>4208 Anthony St. Kensington Md.</i>			
PHYSICIAN'S NAME (Type) <i>Sarah Elizabeth Glover, M.D.</i>				DATE SIGNED <i>8-24-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>8-27-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>		22d. LOCATION (City, town, or county) (State) <i>Gaithersburg Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Christ E. Galtner, Gaithersburg Md.</i>				40. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Wm. L. S. Cooke</i>	

RECEIVED
JUL 29 1966

AUG 29 1966

RECEIVED
JUL 29 1966

CERTIFICATE OF DEATH

Reg. Dist. No. 08492
173

8430

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL (and give nearest town)) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		127	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7610 Blair Road</u>				d. STREET ADDRESS <u>7610-Blair Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest</u> First Middle Last <u>Opitz</u>				4. DATE OF DEATH <u>August 16</u> 19 <u>56</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/11/1894</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Opitz</u>				14. MOTHER'S MAIDEN NAME <u>Attile Scheerer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.H. 1.216096713</u>		17. INFORMANT <u>Goldie Opitz, Wife</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>							
DUE TO (b) <u>Generalized Cancer (Primary</u>						8 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>site unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>56</u> , to <u>Aug 16</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 16</u> 19 <u>56</u> , and that death occurred at <u>1:30 M</u> from the causes and on the date stated above.							
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>56</u> , to <u>Aug 16</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 16</u> 19 <u>56</u> , and that death occurred at <u>1:30 M</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Sanford J Randall</u> M.D. <u>3636 16 ST. N.W.</u> <u>D.C.</u>							
PHYSICIAN'S NAME (Type) <u>SANFORD J. RANDALL, M.D.</u>				<u>8/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-20-1956</u>		<u>Arlington MTA</u>		<u>27 Maywood Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Robert A. Mattingly Wash.</u>				<u>131-11th St. S.E.</u>		<u>Aug 20 1956</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 20 1956

BUREAU V. B.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

8532

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville	
3. NAME OF DECEASED (Type or print) First Middle Last Paula -N- OPPENHEIMER		4. DATE OF DEATH Month Day Year August 5 1956	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 April 1947
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph L. OPPENHEIMER		14. MOTHER'S MAIDEN NAME Wilma FAVIER NEWMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address (Father) Joseph L. OPPENHEIMER (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalitis unclassified 44X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Internal hydrocephalus communicating		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 13 July 1956 to 5 August 1956 , that I last saw the deceased alive on 5 August 1956 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.H. Druckemiller M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Maryland DATE SIGNED 8-7-56	
PHYSICIAN'S NAME (Type) W.H. DRUCKEMILLER, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Maryland 8-7-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-7-56	22c. NAME OF CEMETERY OR CREMATORY Arlington, National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home		24a. REC'D BY REGISTRAR 8-5-56	24b. REGISTRAR'S SIGNATURE Mary E. Sarsely

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BLANK V. 2

116

1750-1751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08494

CERTIFICATE OF DEATH

Reg. Dist. No. 223

8431

1 PLACE OF DEATH a. COUNTY MONTGOMERY Co MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 4 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium				d. STREET ADDRESS 9810 GEORGIA AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Mitchell Last Owens				4. DATE OF DEATH Month August Day 13 , Year 56			
5 SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH DEC 4, 1865	
9 AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 13 Days 19 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) DC.				12 CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME JOHN MITCHELL				14 MOTHER'S MAIDEN NAME Lillian SLICER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT HOSPITAL RECORDS Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma rectosigmoid DUE TO extensive metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal Diabetic Coma DUE TO — (c) — INTERVAL BETWEEN ONSET AND DEATH 9 yrs 6 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) congestive heart failure hypertension diabetes mellitus senility 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		20c. TIME OF INJURY Month, Day, Year Hour — a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) — (County) — (State) —		21. I certify that I attended the deceased from August 12, 1956 to Aug 13, 1956 , that I last saw the deceased alive on Aug 13, 1956 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth Laughlin		ADDRESS (Street, city or town, state) 934 Chesapeake Dr Silver Spring Md		DATE SIGNED 8-13-56			
PHYSICIAN'S NAME (Type) Kenneth Laughlin, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/56		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) Washington, D. C. (State) —	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. H. Hines Co ADDRESS Washington, D. C.				24a. REC'D BY REGISTRAR — DATE 8/14/56		24b. REGISTRAR'S SIGNATURE —	

BUREAU V. B.

UG 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08495

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville	
c. LENGTH OF STAY IN 1b 20 yrs.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF Margaret B. Parsley (Type or print) First Middle Last		4. DATE OF DEATH Aug. 13, 1956 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 30, 1906
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Algernon Johnson		14. MOTHER'S MAIDEN NAME Eliz. Grimsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) #####		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT E rnest Parsley		Address Brookeville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 16	22c. NAME OF CEMETERY OR CREMATORY Jennings Chapel	22d. LOCATION (City, town, or county) (State) Howard Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR 8-15-56	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used in burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. T.

AUG 10 1950

RECEIVED

8432

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edmond</u> Last <u>Patterson</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>22</u> - Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-45</u> 77 yrs
9. AGE (In years last birthday) <u>11</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Sharp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-21</u> - , 19 <u>56</u> , to <u>8-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-22-56</u> , 19 <u>56</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ruth Standard</u>		DATE SIGNED <u>8-22-56</u>	
PHYSICIAN'S NAME (Type) <u>RUTH STANDARD, M.D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery Prince Geo Co.</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW HC</u>		24a. REC'D BY REGISTRAR <u>8/23/56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 41 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1056

1056

1056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

770

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE DISTRICT of COLUMBIA COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 119 69th. Place, N.E.	
3. NAME OF DECEASED (Type or print) First Joseph JOSEPH Middle RALPH Last PEARSON		4. DATE OF DEATH Month AUGUST Day 26 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEB. 9, 1920
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Pearson		14. MOTHER'S MAIDEN NAME Bessie I. Drury	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT Hosp. Rec.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARACHNOIDITIS and LOW GRADE HYDROCEPHALUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONCUSSION and SUBARACHNOID HEMORRHAGE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 49 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Left Leg			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from Scaffold while painting	
20c. TIME OF INJURY Month, Day, Year 3:40 P.M. 7-7- 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bolling Alley		20f. (City or town) Silver Spring, Mont., Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER XX	
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF 8-29-1956	
22c. NAME OF CEMETERY OR CREMATORY Washington		22d. LOCATION (City, town, or county) XX Myer, Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mottin		ADDRESS 131-11 24th St	
24a. REC'D BY REGISTRAR Aug 29 1956		24b. REGISTRAR'S SIGNATURE J. Wilson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 29 1956

RECEIVED

8534

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Lexington			
c. LENGTH OF STAY IN 1b 17 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington			
d. NAME OF HOSPITAL (If not in hospital, name place of death) OR INSTITUTION The Clinical Center				d. STREET ADDRESS National Institutes of Health, Bethesda, Md., Parkers Mill Road, Rt. #2			
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Prudence R. Peel				4. DATE OF DEATH Month Day Year August 16, 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1890	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 9 22	IF UNDER 24 HRS 16, 1956	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY --			11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Fred Rogers				
14. MOTHER'S MAIDEN NAME Elizabeth Woner			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT The Medical Record, Clinical Center				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 17 dx DUE TO RECURRENT CARCINOMA OF ENDOMETRIUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCITES + PERITONEAL IMPLANTS DUE TO CARCINOMA OF ENDOMETRIUM (c) CARCINOMA OF ENDOMETRIUM			INTERVAL BETWEEN ONSET AND DEATH 3 days 1 month 20 months				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from July 30, 1956 , to August 16, 1956 , that I last saw the deceased alive on August 16, 1956 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Peter D. Olch, M.D.				DATE SIGNED 8-16-56			
ACTUAL SIGNATURE Peter D. Olch, M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Peter D. Olch, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 8/17/56		22c. NAME OF CEMETERY OR CREMATORY Bellview Cemetery		22d. LOCATION (City, town, or county) (State) Boyle County Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. -Bethesda				24a. REC'D BY REGISTRAR 8-20-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

В. А. ЛУЗНЕЦ

9961 27 50.

В. А. ЛУЗНЕЦ

8535

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 43 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. STREET ADDRESS 5343 Nevada Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Washington PETTITT		4. DATE OF DEATH Month Day Year August 9 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Jan. 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George PETTITT		14. MOTHER'S MAIDEN NAME Annie Dickerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW-I & II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Sister) Mrs. Elsie May Popkins (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Esophagus</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>26 June</u> , 19 <u>56</u> , to <u>9 August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 August</u> , 19 <u>56</u> , and that death occurred at <u>1:02 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>T.S. Dunn Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>8-10-56</u> PHYSICIAN'S NAME (Type) <u>T.S. DUNN JR. LT MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-13-56	22c. NAME OF CEMETERY OR CREMATORY Acquire Cemetery	22d. LOCATION (City, town, or county) (State) Stafford County Va.
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.E. Humphrey</u> W.E. Humphrey Funeral Home, 8434 Georgia Ave.,		24a. REC'D BY REGISTRAR DATE 9 Aug. 56	24b. REGISTRAR'S SIGNATURE <u>Mary E. Carroll</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



PROCEEDINGS

OF THE

LEGISLATIVE COUNCIL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08500

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarkstown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>73 Hammond Dr</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarkstown</u> d. STREET ADDRESS <u>73 Hammond Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Livingston James Phillips</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-5-1929</u> 9. AGE (In years last birthday) <u>27</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>W. U. S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Arnold Phillips</u> 14. MOTHER'S MAIDEN NAME <u>Marie Hallandworth</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>227-34 3530</u> 17. INFORMANT <u>Frank Phillips (Bro.)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Prosch</u> M.D. EXAMINER'S NAME (Type) <u>Frank J. Prosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/3/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>				22d. LOCATION (City, town, or county) (State) <u>Clarkstown</u> <u>md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS <u>Bonnesville 72d</u>				24a. REC'D BY REGISTRAR <u>Charles W. Elgin</u> DATE <u>8/2/1956</u>		24b. REGISTRAR'S SIGNATURE <u>per wgt.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8537

CERTIFICATE OF DEATH

85501

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chevy Chase</u> c. LENGTH OF STAY IN b. <u>5 mon.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4740 Bradley Blvd.</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chevy Chase</u> d. STREET ADDRESS <u>4740 Bradley Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JULIET</u> First <u>PIDGEON</u> Middle <u></u> Last 4. DATE OF DEATH <u>August 28,</u> Month <u>19 56</u> Day <u>19 56</u> Year			5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 11, 1886</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR <u>9</u> Months <u>17</u> Days IF UNDER 24 HRS <u></u> Hours <u></u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Un-employed</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u> 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Edward Pidgeon</u> 14. MOTHER'S MAIDEN NAME <u>Mary Dudt</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u> 16. SOCIAL SECURITY NO. <u>056-01-8578</u> 17. INFORMANT <u>Mrs Wm. Dambach-Item# 2</u> Address <u></u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular heart disease (mitral & aortic) chronic</u> DUE TO (b) <u>Rheumatic fever in childhood</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Metastatic carcinoma to lungs (Primary breast)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u></u> o. m. <u></u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State) <u></u>		21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Aug 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>56</u> , and that death occurred at <u>7:35</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2200 - 19th N.W. Wash. D.C.</u> DATE SIGNED <u>2200 - 19th N.W. Wash. D.C.</u> ACTUAL SIGNATURE <u>E. W. Nicklas</u> M.D. PHYSICIAN'S NAME (Type) <u>Edward W. Nicklas</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/31/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Brisbin Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Brisbin, Penna.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS <u></u> 24a. REC'D BY REGISTRAR <u>28-56</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. 2

AUG 30 1957

RECEIVED

8538

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived II institution; Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA RURAL		c. LENGTH OF STAY IN 1b 24 DAYS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		d. STREET ADDRESS 1530 "O" STREET N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANGELA Middle CATHERINE Last FIRRONE		4. DATE OF DEATH Month AUGUST Day 12 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 JUNE, 1872
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) ITALY
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME PAUL SANSONE	
14. MOTHER'S MAIDEN NAME ANGELA CATHERINE SANSONE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NOT KNOWN		17. INFORMANT ANNE VECCHIETTI Address 1530 "O" STREET N.W. WASHINGTON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 32X cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 20 July , 1956 , to 12 August , 1956 , that I last saw the deceased alive on 12 August , 1956 , and that death occurred at 1050A M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Gerald I. Shugoll		ADDRESS (Street, city or town, state) DATE SIGNED U.S. NAVAL HOSPITAL, N.N.M.C. 8-12-56 BETHESDA, MD.	
PHYSICIAN'S NAME (Type) Gerald I. SHUGOLL, LT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/16/56	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company, 2901 14th St.		24a. REC'D BY REGISTRAR DATE 8-13-56	24b. REGISTRAR'S SIGNATURE Mary E. Cassell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

AUG 14 1956

RECEIVED

8434

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>3214 Calston Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Smithsonian Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ramsey Pollock</u>				4. DATE OF DEATH Month Day Year <u>August 6 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-70</u>	
9. AGE (in years, last birthday) <u>86 yrs</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James T. Pollock</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of breast with metastasis</u> DUE TO <u>to left chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 1956, to <u>August 6</u> , 1956, that I last saw the deceased alive on <u>August 6</u> , 1956, and that death occurred at <u>7:15 p.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.				DATE SIGNED <u>8/27/56</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>8/8/56</u>		<u>WOODLAND CEMETERY</u>		<u>DAYTON, OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>8434 So the SS</u>		24a. REC'D BY REGISTRAR <u>8/9/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. E. Dool</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8539

CERTIFICATE OF DEATH

185514

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>Route 2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Amanda Pope</u>				4. DATE OF DEATH Month Day Year <u>Aug. 22 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1893</u>	9. AGE (In year last birthday) <u>63</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Clarksburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bradley Etchison</u>				14. MOTHER'S MAIDEN NAME <u>Ella Warfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Flora Mobley, Rt. 3, Gaithersburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEUKEMIA</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic heart disease 10 yrs</u> (c) <u>Nephrosclerosis</u> 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Backogenic carcinoma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>THE DEATH</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat wh le <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 22, 1956</u> to <u>August 22, 1956</u> , that I last saw the deceased alive on <u>August 22, 1956</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Kershner, M.D.</u>				ADDRESS (Street, city or town, state) <u>350 W. Montgomery Ave. Rockville, Md.</u>		DATE SIGNED <u>Aug 22, 1956</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 25, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Clagettville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas L McChesney</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>24-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08505

8540

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville	
c. LENGTH OF STAY IN lb 84 Years		d. STREET ADDRESS Laytonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUCY First NEWMAN Middle PRATHER Last		4. DATE OF DEATH AUG Month 8 Day 19 Year 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5 1872
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) midwife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Clagett		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) #####		16. SOCIAL SECURITY NO. #####	
17. INFORMANT Cora Simpson, Laytonsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corony Embolism. 240 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH immediate 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiorenal D.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour D. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4, 1952 to August 8, 1956 , that I last saw the deceased alive on August 8, 1956 , and that death occurred at 1:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt 1 Silver Spring, Md. DATE SIGNED			
ACTUAL SIGNATURE Webster Sewell M.D.		PHYSICIAN'S NAME (Type) Webster Sewell, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 10	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Mt. Zion Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE 8-11-56	
24b. REGISTRAR'S SIGNATURE Gertrude B Lawler			

RECEIVED

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8541

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE WADE PRICE				4. DATE OF DEATH Month Day Year August 12, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Feb 1876		9. AGE (In years last birthday) yrs 80		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas H. Price				14. MOTHER'S MAIDEN NAME Virginia Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. R. Victoria Price, Hyattstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis, @ Parkinson's Disease.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 52 , to 12 Aug. , 19 56 , that I last saw the deceased alive on 4 Aug. , 19 56 , and that death occurred at 7 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith		M.D. Barnesville, Md		ADDRESS (Street, city or town, state) Barnesville, Maryland		DATE SIGNED 13 Aug 56	
NAME (Type) Gordon M. Smith, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 14 Aug 1956		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Hyattstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland				ADDRESS Hyattstown, Maryland		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Della Burdette			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8542

CERTIFICATE OF DEATH

08507

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN SILVER SPRING		1 1/2 yrs.		TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1539 N. FALKLAND LANE				STREET ADDRESS (If rural give location) 1539 N. FALKLAND LANE			
3. NAME OF (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
JOSEPH JAMES QUIGLEY				AUG. 28 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	APRIL 24, 1906	50 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
MULTILITH OPERATOR			McArdle Printing Co.		WASHINGTON, D.C.		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN D. QUIGLEY				MARY E. HICKEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Mrs. Mary E. Quigley 1539 N. Falkland Lane, Silver Spring, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)				Coronary occlusion		1/2 hour	
ANTECEDENT CAUSE(S) DUE TO				Generalized arteriosclerosis		2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Ischemic heart disease		10 yrs.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1944 to Dec 1956, that I last saw the deceased alive on 1/26/56, 1956, and that death occurred at 12:45 A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Francis J. Becker				M.D. 9/15/1956 58 McArdle			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
ENTOMBMENT		8/31/56		FT. LINCOLN CEMETERY		PRINCE GEORGE COUNTY, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 9/5/56		Francis J. Becker		Edward E. Humphrey		SILVER SPRING, MD.	

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08518
223

8435

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>2013 Oglethorpe</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Mary</u> Last <u>Quinn</u>				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u> <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8, 1911</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Hickey</u>				14. MOTHER'S MAIDEN NAME <u>HELENA REDDY</u> <u>Nellie O'Malley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Raymond Quinn</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acicular embolism & Rheumatic V.D.</u> <u>4-16*</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>approx 10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 28, 1956</u> to <u>Aug 29, 1956</u> ; that I last saw the deceased alive on <u>Aug 26, 1956</u> , 19 _____, and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Wayne Elchfield</u> M.D. <u>6826 Papp Road</u>							
PHYSICIAN'S NAME (Type) <u>H. WAYNE ELCHFIELD</u>				<u>Hyattsville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick</u>		22d. LOCATION (City, town, or county) (State) <u>Aurora N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>				ADDRESS <u>Riverdale, Md</u>		24a. REC'D BY REGISTRAR <u>AUG 31 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Johnston</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-11-11

8543

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>		LENGTH OF STAY (in this place) <u>32</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmor Sanitarium & Hospital 5721 Grosvenor Lane, Bethesda, Md</u>				STREET ADDRESS <u>5730 MacArthur Blvd. Washington, D.C.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Ethel MacDonald. Randolph.</u>				<u>8 14 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>M</u>	8. DATE OF BIRTH: <u>23 May 1889</u>	9. AGE last birthday: <u>67</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Teacher</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Educational</u>		11. BIRTHPLACE (State or foreign country):	
13. FATHER'S NAME: <u>George W. MacDonald</u>				14. MOTHER'S MAIDEN NAME: <u>✓</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Frank P. Randolph. 5730 MacArthur Blvd. Washington, 16, D.C.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE <u>Bronchopneumonia</u>		<u>1 wk</u>
(B) ANTECEDENT CAUSE (S) <u>Septicemia</u>		<u>10 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>Abcess of left Submaxillary gland.</u>		<u>1 mo 11 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus, Cerebral-vascular degeneration</u>		<u>24 yrs</u> <u>5 yrs</u>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>8-1</u> , 19 <u>48</u> , to <u>3-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-14</u> , 19 <u>56</u> , and that death occurred at <u>4:10</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>Memorial Park Cemetery</u>		DATE SIGNED <u>8/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8/18/56</u>	NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	LOCATION (City, town, or county) (State) <u>Evanston, Illinois</u>
DATE REC'D BY LOCAL REGISTRAR <u>8-16-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Martin W. Thompson</u> ADDRESS <u>1300 N. 89th St. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 20 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8436

CERTIFICATE OF DEATH

Reg. Dist. No. 851473

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanitarium</u>		d. STREET ADDRESS <u>45-19 Powder Mill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest Nelson Rhoads</u>		4. DATE OF DEATH <u>8-9-1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-91 65 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Remington Land.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Daniel Rhoads</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>007-20-7497</u>	
17. INFORMANT <u>Marie Rhoads</u>		Address <u>4519 Powder Mill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Coronary Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Seven days</u> <u>Unknown</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1956</u> to <u>Aug 9, 1956</u> , that I last saw the deceased alive on <u>Aug 9, 1956</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL <u>Robert A Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>8/9/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert A Hare</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND</u>	22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Penna</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers G.</u>		24b. REGISTRAR'S SIGNATURE <u>Helen Catodis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 14 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 12-1-56

CERTIFICATE OF DEATH

08511

Reg. Dist. No. 223

8437

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>6 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Livingston San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2840 - 16th St., N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF (Type or print) First Middle Last <u>Thomas James Paul</u>		4. DATE OF DEATH Month Day Year <u>8 8 1956</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-74</u>		9. AGE (In years last birthday) <u>52 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Light House Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>				11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>					
13. FATHER'S NAME <u>Thomas A. Paul</u>								14. MOTHER'S MAIDEN NAME <u>Mary Delane</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Cheryl</u>				Address <u>Cheryl</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis in a. & l. leg. il</u> <u>404.1</u> DUE TO <u>arteriosclerosis in a. & l. leg. il</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>arteriosclerosis in a. & l. leg. il</u> (b) <u>arteriosclerosis in a. & l. leg. il</u> DUE TO <u>arteriosclerosis in a. & l. leg. il</u> (c) <u>arteriosclerosis in a. & l. leg. il</u> </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH <u>not done in home 68 days</u> </div> </div>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>8 2 56</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Olney, Montgomery, Md</u>					
21. I certify that I attended the deceased from <u>Jan 1 1956</u> to <u>Aug 8 1956</u> that I last saw the deceased alive on <u>Aug 8 1956</u> and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.																	
ACTUAL SIGNATURE <u>5431</u>								DATE SIGNED <u>500</u>									
NAME (Type)																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/9/56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>				22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Therese Williams</u>								ADDRESS <u>3821-14 St. N.W.</u>									
24a. REC'D BY REGISTRAR <u>DATE 8/9/56</u>				24b. REGISTRAR'S SIGNATURE <u>J. Allen Doherty</u>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 11 1936

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8544

CERTIFICATE OF DEATH

Reg. Dist. No.

85512
278

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>		d. STREET ADDRESS <u>3820 Warner R. St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cyrus Weed Sherman</u>		4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ezra Sherman</u>		14. MOTHER'S MAIDEN NAME <u>MARY Tarbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MRS. GRACE G. SHERMAN</u> Address <u>Same as address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>Hypostatic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intertrochanteric fracture, rt. femur</u> DUE TO (c) <u>Intertrochanteric fracture, rt. femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours.</u> <u>4 days.</u> <u>7 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, microcyte non-specific chronic, severe.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased fell out of bed at his home.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4 8 4 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Kensington Mont. Ind.</u>	
21. I certify that I attended the deceased from <u>March 12, 1952</u> to <u>Aug 11, 1956</u> , that I last saw the deceased alive on <u>Aug 10, 1956</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. N. Hindman</u>		ADDRESS (Street, city or town, state) <u>3935 Baltimore St. Kensington Md.</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS A. N. HINDMAN</u>		DATE SIGNED <u>8/11/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 8-13-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Churchill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Framingham Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	
24a. REC'D BY REGISTRAR <u>8-14/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

AUG 16 1956

RECEIVED

8438

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>4423 ST Baltimore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Herbert</u> Last <u>Short</u>				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Short</u>				14. MOTHER'S MAIDEN NAME <u>Susie Nichols</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Carrie Short</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Leukemic infiltration of kidneys</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute lymphatic leukemia</u> DUE TO (c) <u>Acute lymphatic leukemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>days?</u> <u>weeks?</u> <u>weeks?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 26, 1956</u> to <u>Aug 29, 1956</u> that I last saw the deceased alive on <u>Aug 26, 1956</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Read N. Calvert</u> M.D. 7894 Georgia Ave, Silver Spring, Md.				DATE SIGNED <u>Aug 29-56</u>			
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT. 7894 Georgia Ave, Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL, SPECIFIC		22b. DATE THEREOF <u>Sept 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Salem</u>		22d. LOCATION (City, town, or county) (State) <u>Brookville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey Bethesda Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BURTON A. G.

1950

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8545 CERTIFICATE OF DEATH

08514
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5615 Virginia Ave.			
3. NAME OF DECEASED (Type or print) First Lissa Middle Anne Last SIMMONS				4. DATE OF DEATH Month August Day 28 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 August 1956	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months 1 Days	IF UNDER 24 HRS Hours 38 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Charles SIMMONS				14. MOTHER'S MAIDEN NAME Anne POWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) George C. Simmons (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURITY DUE TO (c) PULMONARY HYALINE MEMBRANE						INTERVAL BETWEEN ONSET AND DEATH 38 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 27 August 1956 to 28 August 1956 , that I last saw the deceased alive on 28 August 1956 , and that death occurred at 8:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel Shuptar		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.		DATE SIGNED 8-29-56			
PHYSICIAN'S NAME (Type) DANIEL SHUPTAR, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-31-56	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 8-29-56	24b. REGISTRAR'S SIGNATURE Mary E. Casella		

BUREAU A. E.

NOV 11 1950

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY Montgomery 8453 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randolph Hills, Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Rd. B & O R R Crossing			d. STREET ADDRESS 12031 Ashley Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Odell Middle Huff Last SKOLAUT			4. DATE OF DEATH Month Aug. Day 12 Year 1956		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/22	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR: Months 5 Days 2 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME John Huff Vance			14. MOTHER'S MAIDEN NAME Rena Hunt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 144-22-4619		17. INFORMANT Address Milton W. Skolaut (husband) Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Extreme 111X DUE TO Body and extremities badly mutilated Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO 					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by B & O Passenger Train			
20c. TIME OF INJURY Hour 10:23 P.M. Month, Day, Year 8/12 19 56	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R R Crossing	20f. (City or town) Rockville	(County) Montg.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/13/56	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-tran	22b. DATE THEREOF 8/13/1956	22c. NAME OF CEMETERY OR CREMATORY Ellwood	22d. LOCATION (City, town, or county) (State) Vance County North Carolina		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wisc. Ave. Bethesda Maryland		24. REC'D BY REGISTRAR 4-1856		24b. REGISTRAR'S SIGNATURE Laurel Kraybill	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 14 1936

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8546
CERTIFICATE OF DEATH

08516

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3920 Mertford Street.,				d. STREET ADDRESS 3920 Mertford Street.,			
3. NAME OF DECEASED (Type or print) First Betty Middle Sue Last Smith				4. DATE OF DEATH Month August Day 28 Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1861	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months 3 Days 27		IF UNDER 24 HRS. Hours 12 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
						12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Bob Brice				14. MOTHER'S MAIDEN NAME Julia Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lottie Brown 3920 Mertford St., Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis, Coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiorenal Hypertension, Decubitus. DUE TO (c) Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 14, 1956 , to Aug. 28, 1956 , that I last saw the deceased alive on Aug. 27, 1956 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring DATE SIGNED Webster Sewell							
ACTUAL SIGNATURE Webster Sewell M.D.							
PHYSICIAN'S NAME (Type) Webster Sewell Norbeck Rt. 1 Silver Spring							
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped		22b. DATE THEREOF 9/1/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Gordonville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suorden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 9-4-56	
				24b. REGISTRAR'S SIGNATURE Benjamin Thompson			

RECEIVED

SEP 6 1950

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8439

CERTIFICATE OF DEATH

08517

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>10311 Brookmore Drive</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Estelle Sonnenman</u>				4. DATE OF DEATH Month Day Year <u>Aug. 8 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/73</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ed. H. Tasker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah D. Graham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mc. Lomonte Sonnenman Same as pt.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>445X Hypostatic Broncho pneumonia</u> DUE TO (b) <u>Cerebro Vascular Accident</u> DUE TO (c) <u>Hypertensive arteriosclerotic C. V. Disease</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7 years?</u> <u>Bronchial Asthma</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Aug. 6</u> 19 <u>56</u> to <u>Aug. 8</u> 19 <u>56</u> that I last saw the deceased alive on <u>Aug. 8</u> 19 <u>56</u> and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <u>Alaska Ave. N.W. Wash. D.C.</u> DATE SIGNED <u>8/8/56</u>							
SIGNATURE <u>Benjamin Isaacson</u> M.D. <u>7733</u>							
PHYSICIAN'S NAME (Type) <u>BENJAMIN ISAACSON</u>							
22a. BURIAL, CREMATION, REMOVAL, SPECIFIC TRANS. & BURIAL <u>8/21/56</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>BOUGANVILLE CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>HIGHLANDS COUNTY, FLORIDA</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey E. Humphrey</u>				ADDRESS <u>8434 9th Ave. S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>8/13/56</u>	
24b. REGISTRAR'S SIGNATURE <u>T. William Deady</u>							

RECEIVED

AUG 14 1956

BUREAU V. S.

08518

MARYLAND

8547

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New Jersey</u> COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>McAfee</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2200 Darrow Street</u>		STREET ADDRESS (If rural, give location) ---	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ROSE</u> (NMI) <u>Sparta</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug</u> <u>18</u> <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 15, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>71</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis Cilurso</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cilurso</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Roy H. Barnes, 2200 Darrow St., Silver Spring, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)...

Carcinomatosis

Antecedent cause(s)

Primary Carcinoma of Esophagus

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c).....

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan, 1956, to Aug 18, 1956, that I last saw the deceased alive on Aug 18, 1956, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL, SPOKE	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Shp. & burial</u>	<u>Aug. 20, 1956</u>	<u>Franklin Catholic Cemetery, Franklin, New Jersey</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>8-20-56</u>	<u>Frances Gatter</u>	<u>Warner E. Humphrey</u>	<u>Silver Spring, Md.</u>	

MAICIN RESERVE FOR BINDING

BUREAU V. S.

AUG 22 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8454

CERTIFICATE OF DEATH

08519

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> <u>ROCKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanitarium</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>LOGAN</u> Last <u>STARR</u>				4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>	
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min <u>56</u>		IF UNDER 24 HRS Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Wister</u>				14. MOTHER'S MAIDEN NAME <u>Sara Egan Bass</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nervous system</u> - <u>Compensated Congestive Failure</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/12/1956</u> , to <u>8/18/1956</u> , that I last saw the deceased alive on <u>8/18/1956</u> , and that death occurred at <u>4:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>915 19th St. N.W. Wash. D.C.</u> DATE SIGNED <u>8/18/56</u>							
ACTUAL SIGNATURE <u>Jack Kleh</u> M.D.				PHYSICIAN'S NAME (Type) <u>Jack Kleh</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/19/1956</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Rawlins Sons, Wash. D.C.</u> ADDRESS <u>915 19th. Street, NW., Wash., DC.</u>				24a. REC'D BY REGISTRAR <u>8-21-56</u> DATE			
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CORONER NOTIFIED AND APPROVED - AUG 19, 1956

BUREAU V. S.

AUG 23 1956

RECEIVED

8548
CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>2220 Washington Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Leonie</u> Middle <u>Sandra</u> Last <u>STASNY</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1922</u>	9. AGE (In years last birthday) yrt. <u>34</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Husband, Edward STASNY (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, hypertatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Adenocarcinoma, colon, metastatic</u> DUE TO (c) <u>Adenocarcinoma, sigmoid colon</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 mos.</u> <u>Indef.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>19 June</u> , 19 <u>56</u> , to <u>19 August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19 August</u> , 19 <u>56</u> , and that death occurred at <u>4:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Maryland</u> DATE SIGNED <u>8-19-56</u>							
ACTUAL SIGNATURE <u>Frederick W. Meyers, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Frederick W. Meyers, Jr. CDR MC USN</u> U.S. Naval Hospital, Bethesda, Md. <u>8-19-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Humphrey</u> ADDRESS <u>1551 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Carroll</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

18521

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 3½ yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4228 Howard St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Newton Last Staub		4. DATE OF DEATH Month 8/20/1956 Day 19 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/1914
9. AGE (In years last birthday) 42 1/2 yrs.		10. IF UNDER 1 YEAR Months 14 Days 18	11. IF UNDER 24 HRS Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Bldg. & Supply Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther Staub		14. MOTHER'S MAIDEN NAME Sara Baulker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Helen Staub (wife)		Address Same as item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic hemorrhage DUE TO shot gun wound in left chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) self inflicted shot gun wound in left chest (heart)	
20c. TIME OF INJURY Month, Day, Year 1:30 PM 8/20/56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Kensington Montg Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/20/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-22-56	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Montgomery Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR 8-23-56 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

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9956

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8550

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8700 COLESVILLE ROAD		d. STREET ADDRESS 1720 FLINTHILL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last LORETTA ANN SWIFT		4. DATE OF DEATH Month Day Year AUGUST 6 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/07
9. AGE (in years last birthday) 49 yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY DEPT. OF INTERIOR	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH McCLELLAND		14. MOTHER'S MAIDEN NAME ANNIE WELCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NO	
17. INFORMANT Mr. Geo. W. Swift, 1720 Flinthill Rd. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (c), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 170X DUE TO GENERAL WEAKNESS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF RIGHT BREAST (c) INTERVAL BETWEEN ONSET AND DEATH 3 minutes 6 mos. 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2 , 19 56 , to Aug 6 , 19 56 , that I last saw the deceased alive on Aug 6 , 19 56 , and that death occurred at 5:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. Fred W. Eastman M.D.			
PHYSICIAN'S NAME (Type) WILFRED W. EASTMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/9/56	
22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey		24a. RECEIVED BY REGISTRAR 8/8/56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE James C. Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18523/6

8551

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4526 Saul Rd</u>				d. STREET ADDRESS <u>4526 Saul Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>McPherson</u> Last <u>Swingle</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>7</u> Year <u>56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 21, 1916</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. post Office employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Hugh F. Swingle</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth M. ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT Address <u>Margaret Swingle (wife) Same as Item 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Smoke and fumes</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>1st & 2nd Degree burnsof 1/2 body & extremities</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVA. BETWEEN ONSET AND DEATH <u>Found</u> <u>dead in burning home</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Found dead in burning home</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>8/7/56</u> Hour <u>12 M</u> a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>				20f. (City or town) <u>Kensington</u> (County) <u>Montg</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 8-9-56</u>				22b. DATE THEREOF <u>8-9-56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Monte Vista Burial Pk</u>				22d. LOCATION (City, town, or county) <u>Washington Co.</u> (State) <u>Tenn</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda Md</u>			
24a. REC'D BY REGISTRAR <u>8-10-56</u>				24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>			

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU OF

UG 1 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

88524

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>9810-102 Ave NW MARYLAND</u>		USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7810-102 AVE SILVER SPRING MARYLAND</u>		e. STREET ADDRESS <u>7810-102 AVE SILVER SPRING MARYLAND</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>TAYLOR</u> Last <u>TAYLOR</u>		4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 14 1867</u> 9. AGE (In years last birthday) <u>88</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>LURAY VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DAVID ALMOND</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE ALMOND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MT. ROBERT PRITCHARD</u>		Address <u>7402-CATLAND AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL 30, 1953</u> , to <u>Aug 1, 1956</u> that I last saw the deceased alive on <u>Aug 1, 1956</u> , and that death occurred at <u>4:28 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5206 Norway Pl, Chevy Chase, MD</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LURAY VA VIRGINIA</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Millburn J. Girkle</u>		24. REC'D BY REGISTRAR <u>268</u>	24b. REGISTRAR'S SIGNATURE <u>Hances</u>

BUREAU V. A.

MAY 2 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08525

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8811 Glenville Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8811 Glenville Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Milton Last Thomas		4. DATE OF DEATH Month 8 Day 21 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/1902
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman printing		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Geo. M. Thomas		14. MOTHER'S MAIDEN NAME Christabelle Craig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Annabelle M. Thomas (wife)		Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 8/21/56	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW		24a. REC'D BY REGISTRAR 8/21/56	
ADDRESS		24b. REGISTRAR'S SIGNATURE Frances [Signature]	

MEDICAL CERTIFICATION

BUREAU V. S.

AUG 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08526
223

8440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Also known as John Anthony Thomas Notariomase</u>				4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-82</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Arminia Serafini</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>139-16-4336</u>			
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>							
DUE TO <u>Hypertension and Cardiovascular Renal Disease 6 years</u>							
DUE TO <u>Myocardial Infarction</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 21, 1956</u> to <u>Aug 18, 1956</u> that I last saw the deceased alive on <u>Aug 18, 1956</u> , and that death occurred at <u>5:32</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Boris Rabkin</u>				ADDRESS (Street, city or town, state) <u>8102 University Ave SE, Wash DC</u>			
DATE SIGNED <u>8/18/56</u>							
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>8/20/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harmon E. Thompson</u>				ADDRESS <u>834 Georgia Ave SE, Wash DC</u>			
24a. REC'D BY REGISTRAR <u>Aug 20 1956</u>				24b. REGISTRAR'S SIGNATURE <u>W. H. Wilson</u>			

BUREAU V. T.

AUG 27 1950

RECEIVED
FBI
AUG 27 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 217

8554

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville				c. LENGTH OF STAY IN 1b 6 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Myrtle Middle A Last Thomas				4. DATE OF DEATH Month Aug Day 3 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1890		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bennet				14. MOTHER'S MAIDEN NAME Elizabeth A. Lindsay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address G. S. Thomas, Burtonsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 53 to Aug , 19 56 , that I last saw the deceased alive on July 19 , 19 56 , and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A.D. Bonifant M.D. Sandy Spring Md 8/3/56 PHYSICIAN'S NAME (Type) A.D. BONIFANT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Uniontown, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter K. Anderson				24a. REC'D BY REGISTRAR DATE 8-7-56		24b. REGISTRAR'S SIGNATURE Bartrude B. Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DISTRICT

1956 (1) 5174

1956 (1) 5174

8441

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium + Hospital</u>		d. STREET ADDRESS <u>2 Frederick Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>George</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-99</u>
9. AGE (In years last birthday) <u>57</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William H. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Hettie G. Andrews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W. W. T.</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Hospital - record -</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung & Lymph nodes</u> DUE TO <u>Primary Carcin. R. Kidney - Nephrectomy 6 mos ago</u> DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 Months</u> <u>2 ± yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>6-24-</u> , 19 <u>56</u> to <u>8-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-14-</u> , 19 <u>56</u> , and that death occurred at <u>8:45 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		DATE SIGNED <u>8/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial</u>	22d. LOCATION (City, town, or county) <u>Frederick Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Yashin</u>		ADDRESS <u>Gaithersburg Md.</u>	
24a. REC'D BY REGISTRAR <u>J. Wilson</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and if any event within 72 hours after death.

BUREAU V. B.

MAY 20 1956

RECEIVED

8555

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4404 16th St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eduardo Marcelo Trimarco				4. DATE OF DEATH Month August Day 17, Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1952		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Argentine		12. CITIZEN OF WHAT COUNTRY? South America	
13. FATHER'S NAME Domingo M. Trimarco				14. MOTHER'S MAIDEN NAME Sara Elena Rvedas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Pseudomonas pneumonia both lung DUE TO (c) acute Leukemia						INTERVAL BETWEEN ONSET AND DEATH 4 days	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 23, 1956 to August 17, 1956 that I last saw the deceased alive on August 17, 1956 and that death occurred at 8:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas Waldman M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 8/17/56	
PHYSICIAN'S NAME (Type) Thomas Waldman, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/18/1956		22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Buenos Aires, Argentine	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR 8-21-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Humphreys			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUKBAU A. B.

UG 23 1955

1955-1956

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8555

CERTIFICATE OF DEATH

Reg. Dist. No.

18531

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Ohio b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 86 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 1705 Manchester Avenue	
3. NAME OF DECEASED (Type or print) First George Middle Melvin Last Triplett		4. DATE OF DEATH Month August Day 15 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1925
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile Agency	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Grant Triplett		14. MOTHER'S MAIDEN NAME Lillie Conkrite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 275-26-9411	
17. INFORMANT The Medical Center Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage from Hottel valve site DUE TO 100% Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral insufficiency with cerebral hypertrophy DUE TO (c) Martain's syndrome.		INTERVAL BETWEEN ONSET AND DEATH Post-op 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 21 , 19 56 , to August 15 , 19 56 , that I last saw the deceased alive on August 15 , 19 56 , and that death occurred at 3:55 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-16-56 ACTUAL SIGNATURE John Ross, Jr. M.D. National Institute of Health PHYSICIAN'S NAME (Type) John Ross, Jr., M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	22b. DATE THEREOF 8/16/1956	22c. NAME OF CEMETERY OR CREMATORY Woodside	22d. LOCATION (City, town, or county) (State) Middletown Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda,		24a. REC'D BY REGISTRAR 8-20-56 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DOUGLAS A. S.

UG ~ 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08532

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6704 Westmorland Ave.				d. STREET ADDRESS 6704 Westmorland Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Claude Middle Edward Last Turner				4. DATE OF DEATH Month Aug Day 31 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/3/1908		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY safeway store		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Turner				14. MOTHER'S MAIDEN NAME SARAH ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Madgel P. Turner (wife) Address Same as Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 42 yrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour 0 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept. 3, 1956		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery Hyattsville		22d. LOCATION (City, town, or county) (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. H. H.		ADDRESS 254 - Carroll St		24a. REC'D BY REGISTRAR 19/56		24b. REGISTRAR'S SIGNATURE J. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

BILLAU V. E.

SEP 4 1900



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8557 CERTIFICATE OF DEATH

Reg. Dist. No. 216

08533

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 40 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 3200 3rd Street, South e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elton Leroy Usilton		4. DATE OF DEATH Month Day Year August 7 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Percy Usilton		14. MOTHER'S MAIDEN NAME Hattie White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 225-05-1975	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 4-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (essential) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 years 13 years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 28, 1956 , to August 7, 1956 , that I last saw the deceased alive on August 7, 1956 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center Bethesda 14, Md. 8/7/56			
ACTUAL SIGNATURE Thomas Vates		M.D. Thomas Vates, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington 1, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Duca		ADDRESS Washington 1, Va.	
24a. REC'D BY REGISTRAR 8-9-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

RECEIVED

13 13 1956

8558
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08534
 214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 20 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 2309 BLUE RIDGE AVE			
3. NAME OF DECEASED (Type or print) ESTELLE WOLFE WALKER				4. DATE OF DEATH AUG. 9 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24 - 1892	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR 10 Months	IF UNDER 24 HRS 13 Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR TELCO.				10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) U S	
13. FATHER'S NAME GARRETT D. WOLFE				14. MOTHER'S MAIDEN NAME Lucenia Cecil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO				16. SOCIAL SECURITY NO. NO			
17. INFORMANT SON				Address 106 ROLLING RD. MC RICHARD G. WALKER, SR - GAITHERSBORO			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO hypertensive heart disease (b) hypertensive heart disease DUE TO hypertensive heart disease (c) hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO							INTERVAL BETWEEN ONSET AND DEATH 1 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1954 to 8-9 , 1956, that I last saw the deceased alive on 8-9-56 , 19 56 , and that death occurred at 4:25 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11602 Georgia Ave Silver Spring Md. DATE SIGNED 8-9-56 ACTUAL SIGNATURE Morris Perry M.D. Morris Perry PHYSICIAN'S NAME (Type) Morris Perry Silver Spring Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8-13-56		22c. NAME OF CEMETERY OR CREMATORY Faithsboro		22d. LOCATION (City, town, county) (State) Faithsboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin M. Thompson				ADDRESS Faithsboro Md.		24a. REC'D BY REGISTRAR (DATE) 8-13-56	
						24b. REGISTRAR'S SIGNATURE Benjamin M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8559

CERTIFICATE OF DEATH

85535

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 4 Dn.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LEWIS ALBERT WALKER				4. DATE OF DEATH Month Day Year AUG 4 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 16, 1911	9. AGE (In years last birthday) 45 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFORMATION OFFICER USPHS		10b. KIND OF BUSINESS OR INDUSTRY USPHS		11. BIRTHPLACE (State of foreign country) KANSAS		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JOSEPH WALKER				14. MOTHER'S MAIDEN NAME MAUDE SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 67-1-10000		17. INFORMANT Address MRS. THELMA WALKER - SILVER SPRING, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 hrs 5 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 8-4 19 56 to 8-4 19 56 that I last saw the deceased alive on 8-4 19 56 , and that death occurred at 5 p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Morris Perry		M.D. 11602 Georgia Ave. Silver Spring, MD		DATE SIGNED 8-9-56			
PHYSICIAN'S NAME (Type) Morris Perry		Maryland					
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF 8/8/56	22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 8-9-56	
						24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

1906

RECEIVED

8560

CERTIFICATE OF DEATH

Reg. Dist. No. 08536 217

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>622 Lincoln Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Mason</u> Last <u>Warner</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/10/26</u>	
9. AGE (In years last birthday) <u>30</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William M. Warner</u>			
14. MOTHER'S MAIDEN NAME <u>Dela</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Hospital Record (Wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia, Acute Myelogenous</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June</u> 1956 to <u>Aug. 15</u> , 1956, that I last saw the deceased alive on <u>Aug. 15</u> , 1956, and that death occurred at <u>2:30 a.m.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D. <u>Southview, Wash. D.C.</u> <u>Aug 16</u> 1956							
PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-18-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>		22d. LOCATION (City, town, or county) (State) <u>FORT MYER, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>WASH. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHINA 1910

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18537

8561

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ednor		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ednor		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oliver Middle Watts Last Jr.				4. DATE OF DEATH Month August Day 27 Year 19 56			
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 27, 1898		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Landscape		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver Watts				14. MOTHER'S MAIDEN NAME Virginia Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT George Watts Address Silver Spring, Md. Route 1 Box 142			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lower Bowel with generalized Metastasis DUE TO Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL Frank J. Broschart M.D. EXAMINER'S NAME (Type) Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/30/56	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/30/56		22c. NAME OF CEMETERY OR CREMATORY Sandy Spring,		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 8/31/56 DATE	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 5 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08538

8443

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	LENGTH OF STAY (in this place) <u>6 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517 Albany Ave</u>		STREET ADDRESS (If rural give location) <u>4209 - N.W.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH:	
(First) <u>LILLIE</u> (Middle) <u>BELLE</u> (Last) <u>WETMER</u>		(Month) <u>8</u> (Day) <u>10</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>10/12/1871</u>
9. AGE last birthday <u>84</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Esbridge Winer</u>		14. MOTHER'S MAIDEN NAME: <u>Abelia Armetious</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
7 IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>		<u>1 day</u>	
ANTECEDENT CAUSE (B) <u>Mod hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Br. Calculus choleliths</u>		<u>4 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>8/6/56</u>		19B. MAJOR FINDINGS OF OPERATION: <u>5</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>0</u> M.	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/6/56</u> , 19 <u>56</u> , to <u>8/10/56</u> , that I last saw the deceased alive on <u>8/7/56</u> , 19 <u>56</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Dr. H. W. Winer</u>		ADDRESS <u>500 W. ...</u> DATE SIGNED <u>8-10-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-13-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. ...</u>		LOCATION (City, town, or county) (State) <u>Bladensburg, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-14-56</u>		REGISTRAR'S SIGNATURE <u>Frances ...</u>	
24. FUNERAL DIRECTOR <u>Dean ...</u>		ADDRESS <u>4212 ...</u>	

Wash DC

RECEIVED

AUG 16 1956

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

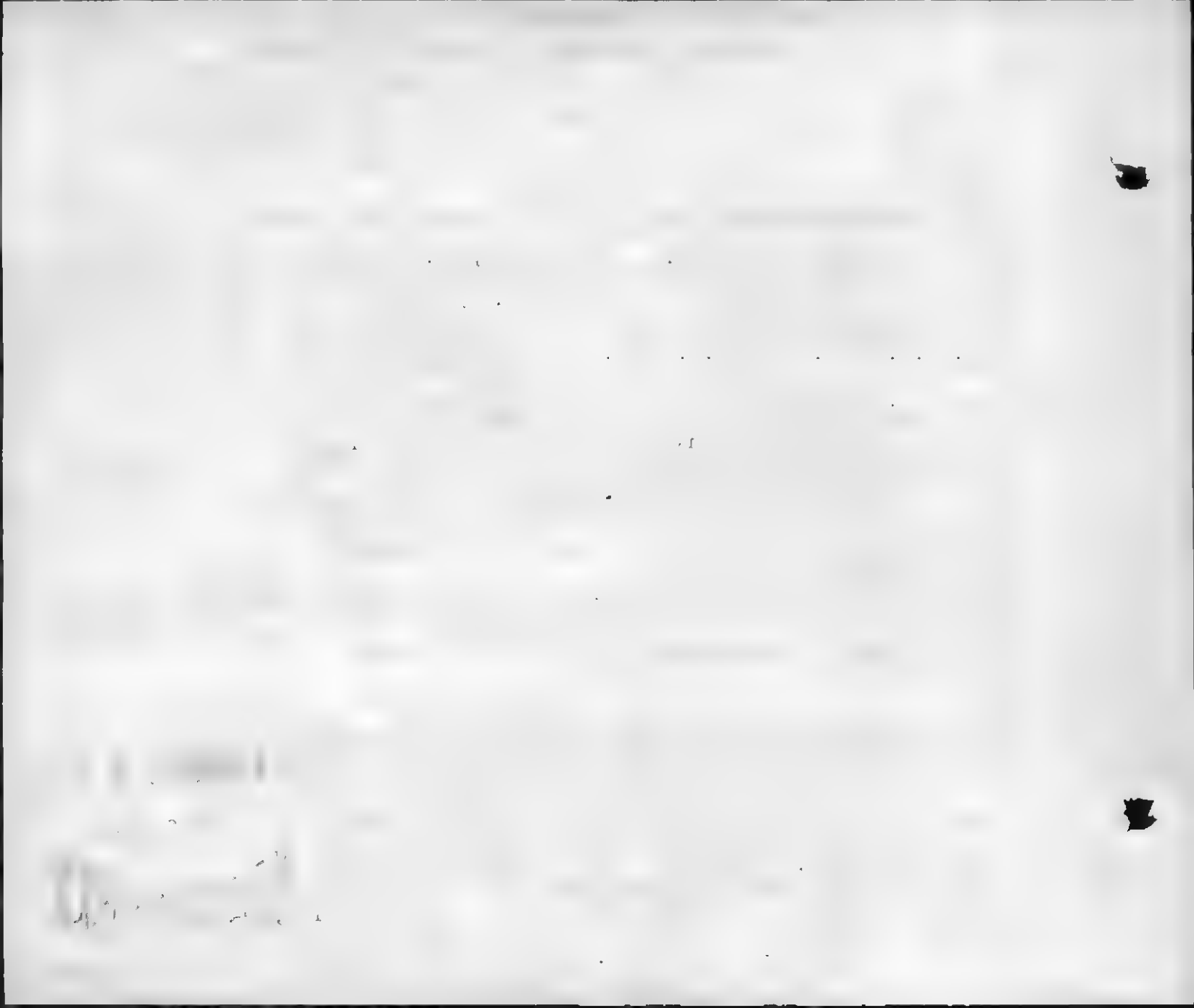
18539

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5808 Kingswood Road</u>				d. STREET ADDRESS <u>5808 Kingswood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>S.</u> Middle <u>WIGHTMAN, Jr.</u> Last				4. DATE OF DEATH <u>August 3,</u> Month <u>1956</u> Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1889</u> <u>Nov. 7, 1889</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>		11. IF UNDER 24 HRS. Hours <u>6</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. U. S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>James S. Wightman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Irene Wightman- Item # 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				DATE SIGNED <u>8/3/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 11 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08540

CERTIFICATE OF DEATH

8563

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING		LENGTH OF STAY (in this place) 3 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN ROCKVILLE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14,511 COLESVILLE ROAD				STREET ADDRESS (If rural give location) R.F.D. # 3, COLESVILLE PIKE			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) BERTHA A. WILLIAMS				4. DATE OF DEATH (Month) (Day) (Year) Aug 28 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 5/18/70	9. AGE last birthday 86 yrs.	10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) KITTANNING, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME HENRIETTA (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Henrietta W. Evinger R.F.D. #3, Colesville Pike Rockville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. IMMEDIATE CAUSE (A) _____				_____		1 1/2 days	
ANTECEDENT CAUSE(S) DUE TO _____				_____		6 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____				_____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____				_____		_____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-31-58 to 8-28-58, that I last saw the deceased alive on 8-27-58, and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
SIGNATURE _____ M.D.				DATE SIGNED 8-28-58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		DATE THEREOF 8/28/58		NAME OF CEMETERY OR CREMATORY HOMWOOD CEMETERY		LOCATION (City, town, or county) (State) PITTSBURG, PENNSYLVANIA	
24. REC'D BY REGISTRAR DATE 8-29-56		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR'S SIGNATURE _____		ADDRESS SILVER SPRING, MD.	

RECEIVED

AUG 31 1946

U.S. AIR FORCE

8564
CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS <u>16th & R Sts., N. W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Salina</u> Middle <u>Virginia</u> Last <u>WOLFE</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1876</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>2</u> Days <u>19</u> Hours <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thurston Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Ashby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Salina Wolfe</u>		Address <u>16th & R Sts. N.W. Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF UTERUS</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u> DUE TO (c) <u>-----</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28, 1956</u> , to <u>Aug. 2, 1956</u> , that I last saw the deceased alive on <u>Aug. 1, 1956</u> , and that death occurred at <u>4:42 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8025 ABERDEEN Rd Bethesda Md</u> DATE SIGNED <u>8/2/56</u>							
ACTUAL SIGNATURE <u>DeWitt E. DeLawter</u> M.D. <u>8025 ABERDEEN Rd Bethesda Md</u>				PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter</u>			
22a. BURIAL CREMATION, (Specify)		22b. DATE THEREOF <u>Aug. 4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Morton W. Hysony Co., 1300-N ST. N.W.</u>				24a. REC'D BY REGISTRAR <u>Aug 3</u>		24b. REGISTRAR'S SIGNATURE <u>Leslie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08542

Reg. Dist. No.

212

8565

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd - RFD</u>				c. LENGTH OF STAY IN 1b <u>Boyd - RFD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Wilburn Woods</u>				4. DATE OF DEATH Month Day Year <u>Aug 5 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 - 1911</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov - N.I.L. laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u> Rufus Woods</u>			
14. MOTHER'S MAIDEN NAME <u>Maggie Lester</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-14-5998</u>				17. INFORMANT Address <u>Mrs Mary V Woods - Boyd - Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct.</u> <u>440.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis with insuffic.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 20, 1949</u> to <u>5 Aug. 1956</u> , that I last saw the deceased alive on <u>5 Aug. 1956</u> , and that death occurred at <u>2:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin H. Smith</u>				ADDRESS (Street, city or town, state) <u>Barnesville, Md</u>			
DATE SIGNED <u>5 Aug 56</u>				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/8/56 Burial</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>				ADDRESS <u>Barnesville, Md</u>			
24a. REC'D BY REGISTRAR <u>9/6/56</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. Elyne</u>			

BUNTAU V. S.

AUG 5 1906

RECEIVED

8444

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		
c. LENGTH OF STAY IN 1b <u>19 yrs</u>			d. STREET ADDRESS <u>808 Kennebec Ave</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>808 Kennebec Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>BERT</u> First <u>ARTHUR</u> Middle <u>WRIGHT</u> Last			4. DATE OF DEATH <u>Aug.</u> Month <u>27</u> Day <u>1956</u> Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (State or foreign country) <u>Leadville, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Crawell Wright</u>			14. MOTHER'S MAIDEN NAME <u>Melissa Brooks</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-2774</u>	17. INFORMANT <u>Mrs. Eva M. Wright (same address)</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, Generalized</u> DUE TO (c) <u>10 years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sanguine Left Heart Fail.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr</u> 19 <u>56</u> , to <u>27 Aug</u> 19 <u>56</u> , that I last saw the deceased alive on <u>27 Aug</u> 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>M. B. Queen</u>		ADDRESS (Street, city or town, state) <u>7112 Willow Ave Takoma Park</u> DATE SIGNED <u>27 Aug 56</u>			
PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 30, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grange Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW. DC</u>		ADDRESS <u>254 Carroll St NW. DC</u>		24a. REC'D BY REGISTRAR <u>J. Wilson Koch</u>	24b. REGISTRAR'S SIGNATURE <u>J. Wilson Koch</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. 31

NOV 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue Springs</u>			
c. LENGTH OF STAY IN 1b <u>45 min.</u>				d. STREET ADDRESS <u>9001 Burnside Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>Yv</u> Last <u>Yadgi</u>				4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-4-82</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <u>Syria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Syria</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
13. FATHER'S NAME <u>XXXXXXXXXXXXX</u> <u>GEORGE MASTRY</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left Ventricular Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASAP</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1955</u> to <u>1956</u> , that I last saw the deceased alive on <u>4-9-56</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.				DATE SIGNED <u>8/30/56</u>			
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				ADDRESS (Street, city or town, state) <u>Five Old Maryland Rd.</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Humphrey</u> ADDRESS <u>434 Georgia Ave SE</u>				24a. REC'D BY REGISTRAR <u>548</u>		24b. REGISTRAR'S SIGNATURE <u>John R. Bell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4 1900

RECEIVED

8565

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Mo. 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last ZAHM		4. DATE OF DEATH Month August Day 28 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 June 1895
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jon Zahm		14. MOTHER'S MAIDEN NAME Henniretta Mettzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Minnie E. ZAHM (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) benign esophageal obstruction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks over 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardio-vascular Disease and Pulmonary Infarctions		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 July 1956 to 28 August 1956 , that I last saw the deceased alive on 28 August 1956 , and that death occurred at 08:20 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-28-56	
ACTUAL SIGNATURE Harold I. Passes, LT, MC, USN		PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-31-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home, 3072 M St., N.W. Wash. D.C.		24a. REC'D BY REGISTRAR 8-28-56	
24b. REGISTRAR'S SIGNATURE Mary E. Passely			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the attending physician and completely filled in by the funeral director may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

BUREAU V. 5

AUG 30 1956

RECEIVED

8567

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Monrovia</i>	c. LENGTH OF STAY IN 1b <i>20 Years</i>	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Monrovia MD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>ELSIE</i> First Middle <i>E. ZEIGLER</i> Last		4. DATE OF DEATH Month <i>AUG</i> Day <i>28</i> Year <i>1956</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>COL</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 14, 1907</i>
9. AGE (In years last birthday) <i>47</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Monro</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>220-012274</i>	
17. INFORMANT <i>Stirling D. Zeigler</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of cervix uteri with</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized metastases</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 1, 1956</i> to <i>August 27, 1956</i> , that I last saw the deceased alive on <i>August 27, 1956</i> , and that death occurred at <i>11:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James P. Kerr</i> M.D.		ADDRESS (Street, city or town, state) <i>Damascus, Md.</i> DATE SIGNED <i>8/29/56</i>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Friendship Mtg</i>		22d. LOCATION (City, town, or county) (State) <i>Montgomery Co MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roy W Barber</i>		24a. REC'D BY REGISTRAR <i>Aug 31</i>	
ADDRESS <i>Laytonville</i>		24b. REGISTRAR'S SIGNATURE <i>Della O. Burdett</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 22 1900

RECEIVED
SEP 22 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8568

CERTIFICATE OF DEATH

Reg. Dist. No. 212

08547

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Montgomery Gen. Hosp.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Beagle, Richard Allen</u>				4. DATE OF DEATH <u>8/18/56</u> Month <u>8</u> Day <u>18</u> Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cool</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/54</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Charles Samuel Beagle</u>				14. MOTHER'S MARDEN NAME <u>Mary Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Charles Beagle</u> Address <u>Montgomery MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction + Hypertension</u> <u>473K</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Transient</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/18</u> , 19 <u>56</u> , to <u>8/19</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>8/18</u> , 19 <u>56</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird, M. D.</u>				ADDRESS (Street, city or town, state) <u>Sancti Spiritus</u> DATE SIGNED <u>8/19/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Md</u>		22d. LOCATION (City, town, or county) <u>Montgomery</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>POY W BARBER</u> ADDRESS <u>LAYTONSVILLE MD</u>				24. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawrence</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

JUG 28 1956

RECEIVED

1956 W

LABOR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

185548

Reg. Dist. No. 215

8559

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 Mo. 16 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 3106 Hawthorne St., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rufus Middle Fairchild Last ZOGBAUM			4. DATE OF DEATH Month August Day 30 Year 1956				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 June 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Rufus ZOGBAUM				14. MOTHER'S MAIDEN NAME Mary Lockwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Sp. Am. WW-I&II		17. INFORMANT (Wife) Mrs. Margaret M. Zogbaum (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Padgett's Disease						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 July , 19 56 , to 30 August , 19 56 , that I last saw the deceased alive on 30 August , 19 56 , and that death occurred at 09:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-30-56							
ACTUAL SIGNATURE John J. Stevens M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) John J. Stevens, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-4-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 8-30-56	
R.A. Humphrey Funeral Home				7557 Wisconsin Ave.		24b. REGISTRAR'S SIGNATURE May L. Bassely	

CERTIFICATE OF MARRIAGE

BUREAU V. 3

SEP 4 1956

RECEIVED